Comprehensive State Plan

2004-2010

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

December 12, 2003

Comprehensive State Plan
2004-2010
Table of Contents

Comprehensive State Plan 2004-2010
Executive Summary

The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services has developed the Comprehensive State Plan 2004-2010 to fulfill its statutory responsibility under § 37.1-48.1) to produce and biennially update a six-year plan for mental health, mental retardation, and substance abuse services. This plan must identify services and supports needs of persons with mental illnesses, mental retardation, or substance use disorders across Virginia, resource requirements, and strategies to address these needs.

The Department is committed to improving Virginia's system of quality treatment, habilitation, and prevention services for individuals and their families whose lives are affected by mental illness, mental retardation, or substance use disorders (alcoholism and other drug addiction). It seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for individuals receiving services.

Title 37.1 of the *Code of Virginia* establishes the Department as the state authority for mental health, mental retardation, and substance abuse services. As the state authority, the Department assures that efficient, accountable, and effective services are available for citizens with the most serious mental disabilities.

Virginia's publicly supported services system includes 16 state facilities and 40 community services boards (CSBs). CSBs are established by local governments and are responsible for delivering community-based mental health, mental retardation, and substance abuse services, either directly or through contracts with private providers. They are the single point of responsibility and authority for assessing individual needs, accessing a comprehensive array of services and supports, and managing state-controlled funds for community-based services. In FY 2002, 107,351 persons received mental health services; 24,903 received mental retardation services; and 59,895 received substance abuse services provided through CSBs. These are unduplicated numbers of individuals receiving services.

The 16 state facilities provide highly structured intensive inpatient treatment and habilitation services. This year, a new behavioral rehabilitation facility was established to provide individualized treatment services in a secure facility to individuals who are civilly committed as sexually violent predators. Current operating bed capacities are 1,798 for state mental health facilities and 1,673 for mental retardation training centers.

FY 2003 funding for Virginia's publicly-funded services system from all sources, including the Department's final adjusted appropriation, local matching funds, all fees, and Medicaid Mental Retardation Waiver payments to private vendors totaled $1.299 billion, of which

- $781.3 million (60 percent) was allocated to CSBs,
- $489.4 million (38 percent) was allocated to state mental health and mental retardation facilities, and
- $28.2 million (2 percent) was allocated to the Department's Central Office.

Estimated Prevalence: By applying prevalence rates from national epidemiological studies and the 2001 National Household Survey on Drug Abuse to Virginia 2000 Census data, the Department estimates that:

- Approximately 394,748 Virginia adults have had a serious mental illness at any time during the past year.
- Between 80,017 and 97,801 Virginia children and adolescents have a serious emotional

disturbance, with between 44,455 and 62,237 exhibiting extreme impairment.

- Approximately 65,062 Virginians have mental retardation.
- Approximately 94,701 Virginia adults and adolescents (age 12 and older) have drug dependence and 142,053 have alcohol dependence.

Only a portion of persons with diagnosable disorders will need services at any given time and an even smaller portion will require or seek services from the public sector.

Service Needs: CSBs used a waiting list database to provide specific information about each individual whom they determined needed but was not currently receiving community services. The following table displays the number of Virginians who were on CSB waiting lists for community mental health, mental retardation, and substance abuse services on April 11, 2003 and on the August 2003 Mental Retardation Home and Community-Based Waiver urgent and non-urgent waiting lists.

Numbers of Individuals on CSB Waiting Lists for Mental Health, Mental Retardation, and Substance Abuse Services by Population

Population	Total Numbers on CSB Waiting Lists
CSB Mental Health Waiting List Count	
Adults with Serious Mental Illnesses	5,030
Children & Adolescents With or At Risk of Serious Emotional Disturbance	1,314
Total MH	6,344
CSB Mental Retardation Waiting List Count	
CSB Non-Waiver Services	2,656
MR Waiver Urgent Waiting List	1,176
MR Waiver Non-Urgent Waiting List	1,259
CSB Substance Abuse Waiting List Count	
Adults with Substance Dependence or Abuse	2,997
Adolescents with Substance Dependence or Abuse	287
Total SA	3,284
Total CSB Mental Health, Mental Retardation, and Substance Abuse Services Waiting List Count	
Grand Total on All CSB Waiting Lists	12,284
MR Waiver Waiting Lists	2,435

This point-in-time methodology is conservative because it does not identify the number of persons who needed services during a year.

There are currently 109 patients in state mental health facilities whose discharges have been delayed due to extraordinary barriers and 173 residents of state mental retardation training centers who, with their legally authorized representative or family member, have chosen to continue their training and habilitation in the community instead of a state training center.

According to Virginia Department of Education, December 1, 2001 counts, there were 14,182 students with a primary disability (as defined by special education law) of emotional disturbance and 13,425 students with mental retardation receiving special education services.

Goals and Future Directions for the Services System: In December 2003, Governor Warner proposed the first stage of a multi-year vision to fundamentally change how mental health, mental retardation, and substance abuse services are delivered and managed in Virginia. This vision would responsibly reduce, through grass-roots strategic planning Virginia's reliance on its state facilities for services that could be more appropriately provided in the community. Seven Regional Partnership planning processes, generally aligned with the state mental health facility service areas, are exploring opportunities to achieve a more fully community-based system of care. Five Special Population Work Groups are examining service needs, challenges, and barriers in addressing the needs of child and adolescent, gero-psychiatric, forensic, mental retardation, and substance abuse populations. Included in the Plan are summaries of the activities of each region and each Special Populations Work Group and initial recommendations made to the Department.

The Plan includes the following goals to enhance and improve Virginia's current services system.

Restructuring Virginia's System of Care

1. Transform Virginia's services system to better meet the needs of individuals with mental illnesses, mental retardation, and substance use disorders and their families.
2. Address the special service and support needs of child and adolescent, gero-psychiatric, forensic, mental retardation and substance abuse populations.
3. Promote the development of a comprehensive array of specialized prevention and treatment services and supports for elderly persons with mental and substance use disorders.
4. Promote the establishment of an integrated system of service delivery that is responsive to the mental health, mental retardation, and substance abuse needs of children and adolescents and their families.
5. Enhance Virginia's capacity to intervene and divert individuals with mental illnesses and substance use disorders from the criminal justice system and enhance the capacity to provide mental health and substance abuse evaluation and treatment services to individuals involved with the criminal justice system.
6. Strengthen the services delivery system for people with mental retardation by restructuring some traditional approaches to services in the community and in state facilities.
7. Make state facility medical and clinical expertise in geriatric medicine, child psychiatry, psychopharmacology, forensic psychiatry, and applied behavior analysis available to CSBs when and to the extent it is required.

Improving Access to Community-Based Services in a Restructured System of Care

8. Work collaboratively on an ongoing basis with the Secretary of Health and Human Resources (HHR) and all State agencies involved in implementing recommendations in the Olmstead Task Force Report.
9. Work collaboratively with the Olmstead Oversight Advisory Committee to assure that the Committee is kept apprised of progress in implementing the recommendations in the Task Force Report for which the Department has primary responsibility.
10. Provide a statewide safety net of short-term intensive intervention community services for all individuals who experience a crisis due to their mental disability or substance use disorder.
11. Develop a comprehensive array of community-based mental health, mental retardation, and substance addiction and abuse services that promote recovery, rehabilitation, employability, and self-determination and choice.
12. Promote and support the implementation of evidence-based practices.

13. Improve the quality and appropriateness of support and treatment for persons with a diagnosis of co-occurring mental retardation and mental illness.
14. Provide, through an integrated approach based on evidence-based practices, appropriate assessments, interventions, and specifically designed programming to persons with co-occurring mental illnesses and substance use disorders.
15. Ensure quality and continuity of care for people who are deaf, hard of hearing, late deafened, or deafblind and are in need of mental health, mental retardation and substance abuse services.
16. Ensure that CSB prevention services address risk and protective factors and service gaps identified by community-based prevention planning coalitions.
17. Reduce the incidence and prevalence of suicide among youth and adults in the Commonwealth.
18. Continue to reduce youth access to tobacco products.

Addressing State Facility Needs in a Restructured System of Care

19. Assure that state mental health and mental retardation facilities provide quality assessment, treatment, rehabilitation, training, and habilitation services that are appropriate to the needs of individual patients and residents.
20. Provide individualized treatment services in a secure environment to individuals civilly committed to the Department as sexually violent predators.
21. Assure that the capital infrastructure of state mental health and mental retardation facilities is safe, appropriate for the provision of current service methods, and efficient to operate.

Assuring Service Quality, Effectiveness, and Responsiveness in a Restructured System of Care

22. Enhance the Department's oversight of quality of care and protection of individuals receiving MH, MR, and SA services and developmental disabilities and brain injury services.
23. Assure the rights of each individual receiving services from providers of mental health, mental retardation, or substance abuse services through a high quality, effective, efficient, and responsive human rights system.
24. Evaluate the need for and effectiveness of uniform clinical guidelines as a tool for improving the quality of state facility treatment, care, and clinical services.
25. Ensure that quality management review functions at the state facility and Department levels are implemented according to clearly articulated policies and procedures.
26. Assure that publicly funded services provided in state facilities and CSBs are based on sound research that assures the highest quality treatment and the best clinical outcomes for the residents of the Commonwealth.
27. Implement a comprehensive and system-wide approach to public mental health utilization.
28. Develop the system's capacity to improve the medication practices of physicians, pharmacists, and nurses who have a role in the medication management process in community and state facility services.
29. Reduce the utilization of seclusion and behavioral restraint in state facilities.

Promoting Self-Advocacy, Self Determination, and Empowerment for Individuals Receiving Mental Health, Mental Retardation, and Substance Abuse Services and Their Families

30. Increase opportunities for individual and family involvement.
31. Improve opportunities for individual and family education and training.

32: Promote and support the implementation of mental health programs that foster empowerment, peer support, and recovery-based services.

33. Provide individuals and families with the opportunity, at both the systems and the individual levels, to determine the types of services they receive, as well as the opportunity to evaluate the quality of those services.

34. Reduce the stigma and shame associated with substance abuse that inhibit people with substance use disorders from seeking help and restrict available resources to support treatment and prevention and increase the impact of individual experience on the service delivery system.

Supporting System Collaboration and Integration

35. Maintain and strengthen the collegial relationship described and operationalized in the Central Office, State Facility, and CSB Partnership Agreement.

36. Encourage and facilitate greater private provider participation in the public mental health, mental retardation, and substance abuse services system.

37. Realize cost savings to the Commonwealth by expanding Medicaid funding for community mental health, mental retardation, and substance abuse services.

38. Increase the stability of families affected by mental illnesses and substance use disorders that are receiving TANF benefits or involved in protective services.

39. Expand safe and affordable housing alternatives that meet the needs of individuals receiving mental health, mental retardation, and substance abuse services.

40. Improve the identification, screening, and diagnosis of substance abuse and substance use disorders and referrals to services by providers of primary health care services.

41. Reduce barriers to employment for youth and adults with mental disabilities.

42. Improve competitive employment opportunities and outcomes for individuals receiving mental health, mental retardation, and substance abuse services.

43. Provide clinical leadership to the Interagency Drug Offender Committee.

44. Assure effective interagency collaboration and coordination necessary to reduce policy fragmentation and improve and enhance services and supports available to individuals with mental illnesses, mental retardation, and substance use disorders.

Strengthening Human Resources Management and Development

45. Partner with public and private organizations and providers to address systemic issues in fielding an adequate workforce within the mental health, mental retardation, and substance abuse services health care system.

46. Enhance the skills and evidence-based knowledge of professionals working in substance abuse treatment and prevention programs.

47. Assure that the system of care for people with mental retardation is safe and efficient and delivered by professional and paraprofessional and direct care staffs that are well trained and motivated to support those who rely on them for their care and treatment.

Preparing for and Responding to Disasters and Terrorism

48. Enable Virginia's mental health, mental retardation, and substance abuse services system to better understand and prepare for the heightened threat potential facing the Commonwealth.

49. Establish structures and relationships that will assure an immediate, effective, and coordinated response to terrorism-related and other major disasters by the mental health, mental retardation, and substance abuse services system.

Implementing Information Technology Strategic Directions

50. Assure that the information technology infrastructure and services provided by the Virginia Information Technologies Agency (VITA) to the Department match the Department's evolving demands in a cost effective manner and perform in a reliable and secure manner.

51. Improve the ability of the Department, state facilities, and CSBs to manage information efficiently in an environment that is responsive to the needs of users and protects identifiable health information for individuals receiving public mental health, mental retardation, and substance abuse services.

Resource Requirements: The Department has identified the following resource requirements to respond to critical issues facing Virginia's services system. Resource requirements that are part of the Department's response to the Olmstead vs. L.C. Supreme Court decision and Virginia's Olmstead Task Force Report are asterisked.

Resource Requirement	FY 2005		FY 2006		Biennium Total	
	SGF	NGF	SGF	NGF	SGF	NGF
* Crisis Stabilization	4,331,250	0	5,775,000	0	10,106,250	0
* PACT Teams	2,219,043	0	4,438,086	0	6,657,129	0
* Local Bed Purchases	6,570,000	0	6,570,000	0	13,140,000	0
* Transitional Residential Services	6,690,000	0	10,380,000	0	17,070,000	0
* Consumer/Family Involvement	110,000	0	110,000	0	220,000	0
* State MH Facility Discharge Waiting Lists	4,518,750	0	6,025,000	0	10,543,750	0
* State MR Facility Discharge Waiting Lists	4,187,211	0	3,004,568	0	7,191,779	0
*Community MH Waiting Lists	9,004,600	0	18,549,500	0	27,554,100	0
* Community MR Waiting Lists	9,479,900	0	19,528,600	0	29,008,500	0
* Community SA Waiting Lists	3,419,200	0	7,043,400	0	10,462,600	0
* Medicaid MR Waiver Rate Increase	15,000,000	15,000,000	15,000,000	15,000,000	30,000,000	30,000,000
* Medicaid MR Waiver Urgent Waiting List	11,600,000	11,600,000	23,200,000	23,200,000	34,800,000	34,800,000
Jail-Based MH/SA Services	477,024	0	491,335	0	968,359	0
* Pilot Forensic Residential Programs	481,988	0	500,000	0	981,988	0

Resource Requirement	FY 2005		FY 2006		Biennium Total	
	SGF	NGF	SGF	NGF	SGF	NGF
Child/Adolescent Service Expansion	4,075,000	0	5,075,000	0	9,150,000	0
Child Psychiatrists & Specialists	3,000,000	0	4,000,000	0	7,000,000	0
Part C Early Intervention Services	3,344,663	0	6,265,363	0	9,610,026	0
MR Services for Children with Complex Needs	675,480	524,520	675,480	524,520	1,350,960	1,049,040
* MI/MR Clinical & Emergency Support Teams	240,000	0	480,000	0	720,000	0
* Restructuring SWVTC MI/MR Waiver Slots	425,000	0	425,000	0	850,000	0
* Regional Community Support Centers (Centers of Excellence)	1,000,000	0	1,000,000	0	2,000,000	0
Evidence-Based Practices	385,000	0	660,000	0	1,045,000	0
Behavioral Rehabilitation Center (SVP) Operation	3,746,667	0	5,740,412	0	9,487,079	0
SVP Community Treatment	325,000	0	534,000	0	859,000	0
State MR Facility Staffing	9,317,552	7,235,215	10,249,307	7,958,736	19,566,859	15,193,951
State MH Facility Staffing	1,446,870	142,228	1,591,482	156,823	3,038,352	299,051
State Facility Medications Costs	2,752,246	440,615	3,303,078	528,355	6,055,324	968,970
State Facility Equipment & Vans	584,175	250,362	584,175	250,362	1,168,350	500,724
State Facility Gas & Fuel Costs	670,960	226,250	686,922	238,761	1,357,882	465,011
State Facility Surrogate Decision Makers	90,000	0	40,000	0	130,000	0
State Facility Revenue Shortfall	14,800,000	0	14,800,000	0	29,600,000	0
Nursing Development, Recruitment/Retention	911,667	0	1,335,924	0	2,247,591	0

Resource Requirement	FY 2005		FY 2006		Biennium Total	
	SGF	NGF	SGF	NGF	SGF	NGF
Terrorism/Disaster Preparedness	172,500	0	172,500	0	345,000	0
CO IT & Facility Operations/Quality Improvement Staff	155,000	0	155,000	0	310,000	0
Replace HP300e Server	950,000	0	0	0	950,000	0
TOTAL	127,158,751	35,421,196	178,391,138	47,859,563	305,545,878	83,276,747

Notes:

Non-general funds include anticipated Medicaid and third party payer fees, direct client fees, and other revenues for community services.

Conclusion: The directions established in the *Comprehensive State Plan for 2004-2010* would enable the Commonwealth to accelerate the shift to a more completely community-based system of care while preserving the important roles and service responsibilities of state mental health and mental retardation facilities in Virginia's public mental health, mental retardation, and substance abuse services system. Its goals would increase community options and individual choice; support opportunities for individual and family member education, training and participation; promote collaborative activities with other agencies and services systems and private sector development; improve services oversight and accountability; advance quality improvement and care coordination; and address system administrative and infrastructure issues.

Through its Reinvestment Initiatives and Regional Restructuring Partnerships, the Department and its operational partners continue to emphasize the transition toward a fully community-based system of care where services emphasize each individual's movement toward recovery, self-determination, and integration into life and work in the community, to the extent possible given the nature of his disability and individual circumstances. In this vision for Virginia's future system of community-based services, state mental health and mental retardation facilities will continue to play an important role in this community-based system of care.

Given current budget constraints, the policy agenda for publicly funded mental health, mental retardation, and substance abuse services for the next biennium continues to focus, to the extent possible, on two key themes:

- Sustainability of the progress that has been achieved, especially for individuals and family members who have benefited from the expansion and improvement of services during the past four years; and
- Clearly focused growth and development efforts to address, to the extent possible, the critical issues facing Virginia's public mental health, mental retardation, and substance abuse services system.

Comprehensive State Plan
2004 - 2010

I. INTRODUCTION

In 1998, the *Code of Virginia* was amended to add §37.1-48.1, which requires the Department of Mental Health, Mental Retardation and Substance Abuse Services (the Department) to develop and update biennially a six-year Comprehensive State Plan for mental health, mental retardation, and substance abuse services. This plan must identify the services and supports needs of persons with mental illnesses, mental retardation, or substance use disorders across Virginia; define resource requirements; and propose strategies to address these needs. That *Code* section also requires that the plan be used in the preparation of the Department's biennium budget submission to the Governor.

The Department's initial Comprehensive State Plan for 1985-1990 proposed a "responsible transition" to a community-based system of services. In 1986, the plan was expanded to cover a six-year time frame, with updates corresponding to the Department's biennium budget submissions. These updates continued until 1995, when agency strategic planning efforts replaced the 1996-2002 Comprehensive State Plan. Biennial updates to the Comprehensive State Plan were reinstated in 1997 with the 1998-2004 Plan.

The Department's Comprehensive State Plan has evolved to serve a number of purposes. The plan:

- Establishes services system priorities and future system directions for the public mental health, mental retardation, and substance abuse services system;
- Describes strategic responses to major issues facing the services system;
- Identifies priority service needs;
- Defines resource requirements and proposed initiatives to respond to these requirements; and
- Helps to integrate the agency's strategic and budget planning activities.

The 2000-2006 Comprehensive State Plan introduced an individualized waiting list database to document service requirements and characteristics of individuals on community services board (CSB) waiting lists. In this Plan, CSB includes local government departments with policy-advisory CSBs and behavioral health authorities. CSB waiting lists included individuals who had sought but were not receiving CSB services and current recipients of CSB services who were not receiving the types or amounts of services that CSB staff had determined they needed. These point-in-time waiting list surveys of the CSBs continued to be used to document community service needs for the 2002-2008 and 2004-2010 plans. The CSB waiting list database provides specific demographic and service information about each individual identified by the CSBs as needing a specific community services or supports. Also included in the database are CSB projected service wait times and prevention service priorities.

In addition to CSB waiting list information, the Department surveyed state facilities to identify individuals who are on their "ready for discharge" lists. These include patients in state mental health facilities whose discharges have been delayed due to extraordinary barriers and residents of state mental retardation training centers who, with their legally authorized representative or family member, have chosen to continue their training and habilitation in the community instead of a training center.

As part of the Department's effort to restructure Virginia's public services system, CSBs, state facilities, individuals receiving services, families, advocates, and other public and private providers in each of the seven regions associated with state mental health facility service areas have been involved in a longer-term strategic planning process. Through this process, the regions are assessing their current services needs and priorities and defining strategies that must be taken in their regions to achieve a truly community-based services system. The Department has asked each Regional Partnership to:

- Engage in dialogue about major issues facing the region;
- Consider and propose regional and state-level actions that would improve the quality of care and service delivery in the region, including:
  - policy, legislative, regulatory, financing, and administrative changes;
  - initiatives for inclusion in the 2004–2010 Comprehensive State Plan and 2004-2006 biennium budget submission; and
  - proposals for significant restructuring of services in the region;
- Recommend strategies to improve regional and local systems of mental health, mental retardation, and substance abuse care to meet the needs of individuals receiving services and achieve efficiencies in administrative functions and service delivery; and
- Assess the region's readiness for significant restructuring of state facility and community services within the region, including the possible future state facility closure or conversion to another use.

Recommendations developed by these Regional Partnerships are incorporated in this plan.

The 2004-2010 Comprehensive State Plan also includes initial recommendations from the five Special Population Work Groups. These work groups are developing strategic plans over the next year to address the needs of the following distinct populations:

- Child and adolescent population,
- Gero-psychiatric population,
- Forensic population,
- Mental retardation population, and
- Substance abuse population

The 2004-2010 Comprehensive State Plan also incorporates recommendations of the Olmstead Task Force pertaining to the Department and services system. This task force was established pursuant to the 2002 Appropriation Act (Item 329 M) to "develop a plan for serving persons with disabilities that implements the recommendations of the Olmstead decision (Olmstead v. L.C., 119 S. Ct. 2176 [1999])." Task force members represented the interests of individuals receiving services across all disability populations and a broad array of public and private service providers at the state and local levels.

The draft 2004-2010 Comprehensive State Plan was distributed for public review and comment on October 29, 2003 and the Department and State Board conducted five public hearings around the state in mid-November to receive public input on the draft Plan. The State Board met on December 12, 2003 to review public hearing testimony and other written comments on the draft plan and to consider changes proposed by the Department in response to this public comment. The Board expressed its support for the Plan.

II. POPULATIONS RECEIVING PUBLIC MENTAL HEALTH, MENTAL RETARDATION, AND SUBSTANCE ABUSE SERVICES AND PREVALENCE ESTIMATES FOR THOSE POPULATIONS

Individuals Who Have a Serious Mental Illness or Serious Emotional Disturbance

A mental disorder is broadly defined in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (the *DSM* IV) as:

> A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment of one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Mental disorders are common. The annual prevalence of these disorders is nearly 20 percent, and the lifetime prevalence of all mental disorders in the general population is 20-25 percent. There have been many significant advances in the treatment of mental illness, to the extent that today, there are many effective treatments for most mental disorders.

In addition to emergency services that are available to any individual in crisis, Virginia's public services system provides services to adults with serious mental illness and children and adolescents (birth through age 17) with or at risk of serious emotional disturbance.

***Serious Mental Illness in Adults**:* Three dimensions define serious mental illness:

- Diagnosis of serious mental illness in the *DSM IV*, including schizophrenia and related disorders, affective disorders such as major depression and bipolar disorders, antisocial and borderline personality disorders, and some other diagnoses;
- Severe, recurrent disability in two or more areas of life functioning, i.e., employment, meeting basic shelter and support needs, interpersonal relations, self-care and activities of daily living, as well as violating community norms; and
- Treatment history that includes intensive services or services needed for an extended duration.

Substance abuse is a very frequent co-occurring disorder with serious mental illness.

***Serious Emotional Disturbance in Youth**:* Serious emotional disturbance in children and adolescents is defined as diagnosis under DSM IV or all of the following:

- Problems in personality development or social functioning exhibited for a year or more,
- Problems that are significantly disabling based on social functioning of most youngsters their age,
- Problems that have become more disabling over time, and
- Service needs that require significant intervention by more than one agency.

Children "At-Risk" of Serious Emotional Disturbance: Children who are "at-risk" of serious emotional disturbance meet the following conditions:

- Behavior or maturity is significantly different from their peers, and is not due to developmental disability or mental retardation,
- Parents have predisposing factors that could result in their children developing serious emotional disturbance, and
- Have experienced physical or psychological stressors that put them at risk for serious emotional or behavior problems.

Individuals Who Have Mental Retardation

Mental retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. Diagnoses of mental retardation, according to the DSM IV-R, are based on levels of sub-average intelligence. This disability originates before the age of 18. The existence of limitations in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the person's individualized needs for supports.

Within each individual, limitations often coexist with strengths. With appropriate personalized supports over a sustained period, the life functioning of the person with mental retardation generally will improve; however, mental retardation is a life long-disability.

Individuals Who Have a Substance-Use Disorder

Substance use disorders are types of mental disorders that are "related to the taking of a drug of abuse (including alcohol), to the side effects of a medication, and to toxin exposure" (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, American Psychiatric Association, 1994). Substance-related disorders can be categorized as either substance *use* disorders (substance dependence and substance abuse) or substance-*induced* disorders, which include intoxication, withdrawal, delirium, psychosis and other conditions caused by substance use. Substances can include prescription drugs, over-the-counter drugs, illegally manufactured drugs, alcohol, and tobacco. Substance *use* disorders may or may not be related to abuse or dependence on a substance.

- Substance *dependence* is characterized by continued use of the substance in spite of "significant substance-related problems" with "a pattern of repeated self-administration that usually results in tolerance, withdrawal and compulsive drug-taking behavior" (DSM IV).
- Substance *abuse* is characterized by "a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances (DSM IV).

Substance-related disorders are related to each other and represent different levels of severity and chronicity. It is entirely possible that one individual may experience several of these conditions in the course of the disorder and will require various levels of treatment appropriate for the diagnosis present at the time. In addition, persons with substance-related disorders may experience other types of mental disorders simultaneously.

Research about the causes of substance-related disorders strongly implicates the existence of a genetic predisposition, combined with environmental factors, including exposure to the specific substance. For instance, one twin is more likely to exhibit symptoms of alcoholism when the other twin is alcohol dependent (Health, et al.). Therefore, a significant amount of attention has been devoted to prevention. In addition, certain physical illnesses are more common in persons with substance-related disorders. In addition to well-known connections between intravenous drug use and HIV/AIDS, tuberculosis, and certain types of hepatitis, certain cancers and other systemic disorders are more common in persons with substance-related disorders.

Individuals Meeting Statutory Criteria as Sexually Violent Predators

Sexually violent predators are convicted sex offenders who are civilly committed to the Department at the end of their confinement in the Department of Corrections because of their histories of habitual sexually violent behavior and because their ability to control their violent tendencies is compromised by the presence of a "mental abnormality" or "personality disorder". These individuals are predominantly male, on average about 40 years old. They have long histories of sexually abusing children and adults and have shown very limited ability or willingness to abstain from committing sexual offenses.

Prevalence Estimates

When planning for Virginia's future public mental health, mental retardation, and substance abuse services system, it is important to have a sense of how many people might seek care from the services system. This section uses national epidemiological studies as the basis for extrapolating Virginia prevalence rates for adults with serious mental illnesses, children and adolescents with serious emotional disturbances, individuals with mental retardation, and individuals with substance use disorders (dependence or abuse). Prevalence is the total number of cases within a year. This differs from incidence, which is the number of new cases within a year. Total population prevalence estimates are based on the 2000 Census for Virginia. The 2000 Census was used because it provided the most current age cohorts.

Estimated Prevalence for Adults with Serious Mental Illnesses: According to the Report of the New Freedom Commission on Mental Illness, *"Achieving the Promise: Transforming Mental Health Care in America,"* (2003), in a given year, about 5 to 7 percent of adults have a serious mental illness, based upon nationally representative studies. The report referenced the 2001 National Household Survey on Drug Abuse (NHSDA), which included questions for adults aged 18 or older to assess serious mental illness. This survey defined serious mental illness as having a diagnosable mental, behavioral, or emotional disorder that met criteria in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and that resulted in functional impairment that substantially interfered with or limited one or more major life activities. The NHSDA survey found an overall rate of past year serious mental illness of 7.3 percent of all adults aged 18 and older, with rates higher among young adults aged 18 to 25 (11.7 percent) than among adults aged 26-49 (7.9 percent) or 50 or older (4.9 percent). By applying these age-specific rates to appropriate cohorts of Virginia's adult population, using 2000 Census data, an estimated 394,748 Virginia adults have a serious mental illness.

Estimated Prevalence for Children and Adolescents With Serious Emotional Disturbance: The methodology for estimating prevalence of serious emotional disturbance was obtained from "*Prevalence of Serious Emotional Disturbance: An Update*" (Friedman et. al., *Mental Health, United States 1998*). In this article, two levels of serious emotional disturbance for children from age 9 to 17 are discussed. Data were insufficient to make prevalence estimates for children younger than nine. The first level, which meets the requirements of the federal definition, projects a prevalence rate of serious emotional disturbance and substantial functional impairment in the range of 9 to 13 percent. The second level, which is characterized as serious emotional disturbance and "extreme functional impairment," projects a prevalence rate in the range of 5 to 9 percent.

The prevalence of serious emotional disturbance was higher for children living in low socioeconomic circumstances and state prevalence estimates were adjusted for this difference. States are rank-ordered by the percentage of children in poverty. The estimated prevalence for the third of the states with the smallest number of children in poverty is from 9 to 11 percent (and 5 to 7 percent for extreme impairment). The estimated prevalence for the middle third of the states is from 10 to 12 percent (and 6 to 8 percent for extreme impairment). The estimated prevalence for the third of states with the highest level of poverty is from 11 to 13 percent (and 7 to 9 percent for extreme impairment). Virginia's percent of children and adolescents living in poverty in 1995 was 14.38 percent, which is in the cohort of states with the smallest number of children in poverty.

Using the 2000 Census data, these prevalence rates were applied to Virginia population data to extrapolate the estimated number of children and adolescents between 9 and 17 years of age with a serious mental illness. Between 80,017 and 97,801 Virginia children and adolescents have a serious emotional disturbance. Of these, between 44,455 and 62,237 have serious emotional disturbance with extreme impairment.

Prevalence of Mental Retardation: With regard to a national prevalence rate for mental retardation, there is no generally accepted figure for the general population, in large part because of differences in the way mental retardation is defined as well as the types of data that have been used to produce the prevalence estimates. In *Closing the Gap, A National Blueprint to Improve the Health of Persons with Mental Retardation: Report of the Surgeon General's Conference on Health Disparities and Mental Retardation, 2002*, Dr. Bonnie Kerker's Overview Presentation on the Prevalence of Mental Retardation cites current data showing that approximately 0.3 to 3.1 percent of the general population, and about 1.1 percent of all children have mental retardation. Most of these individuals are classified as having mild mental retardation.

A 1993 study of mental retardation prevalence rates, *State Specific Rates of Mental Retardation – United States, 1993*. MMWR Weekly (Jan. 26, 1996), 45, #3: 61-65, used data from the U.S. Department of Education for children with mental retardation who were enrolled in special education programs and data from the Social Security Administration (SSA) to estimate the mental retardation prevalence rates per 1,000 population. These rates were applied to Virginia's population, using 2000 Census data, to extrapolate the following prevalence estimates:

- Prevalence among adults (ages 18-64): 45,336
  (1.0 percent or 6.1 cases per 1,000)
- Prevalence among children (ages 6-17): 14,166
  (1.2 percent, or 11.8 cases per 1,000)
- Overall prevalence (over age 6): 65,062
  (1.0 percent, or 7.2 cases per 1,000)

It should be noted that the methodological limitations of this study are likely to have produced relatively conservative estimates of the prevalence of mental retardation. For example, Department of Education data does not include individuals who never enrolled in or who dropped out of school, and SSA eligibility, because it is based on both personal income and the presence of a disability, may exclude adults with mental retardation who do not meet SSA income eligibility requirements.

Prevalence of Substance Dependence: Prevalence estimates of substance dependence (addiction) in the past year for individuals who are age 12 and over were obtained from the 2001 National Household Survey on Drug Abuse (NHSDA). Using 2000 Census data, these prevalence rates were applied to Virginia population data to extrapolate the estimated prevalence of dependence in Virginia. The estimated prevalence of adults and adolescents reporting past year dependence on any illicit drug is 1.6 percent, or 94,701 Virginians. The estimated prevalence of past year alcohol dependence is 2.4 percent, or 142,052 Virginians. The total estimate in that time frame for any illicit drug or alcohol dependence is 3.6 percent, or 213,073 Virginians.

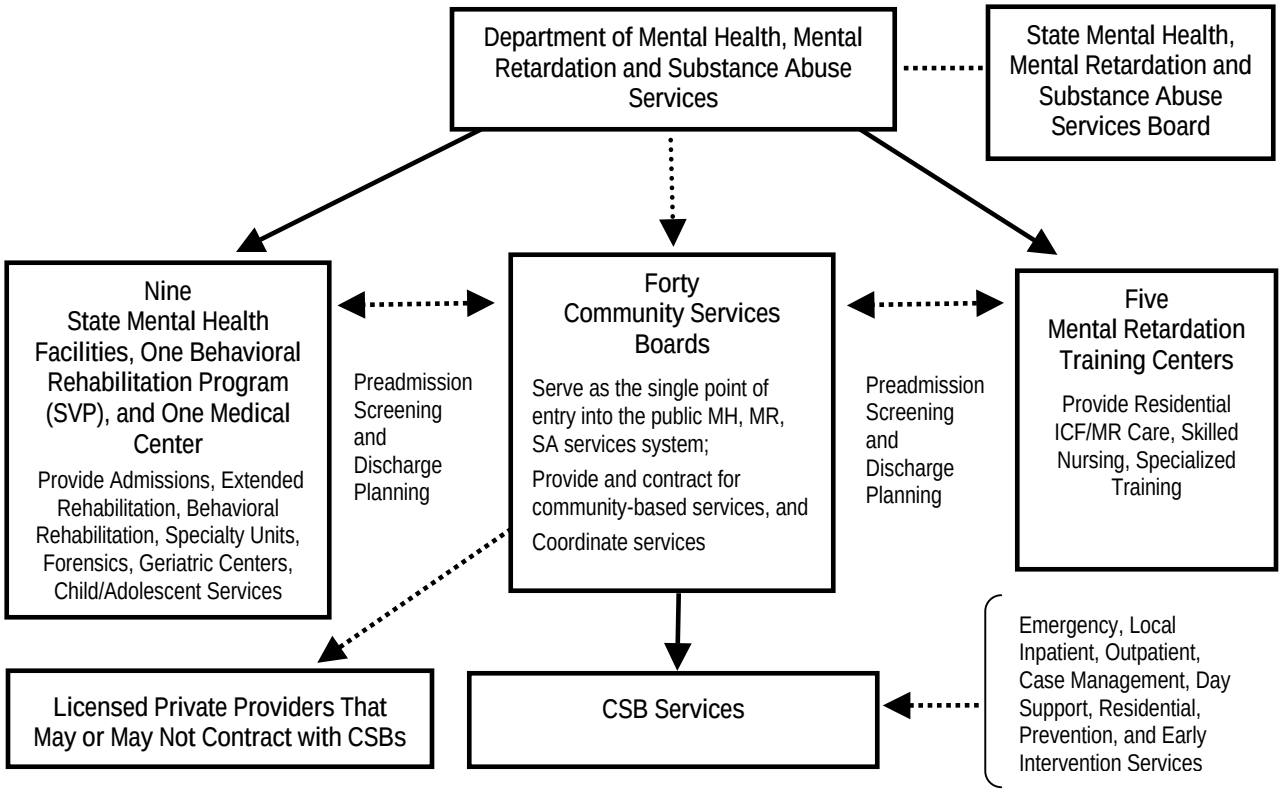
Appendix A contains prevalence estimates for serious mental illness, serious emotional disturbance, mental retardation, and substance dependence by CSB.

III. SERVICES SYSTEM OVERVIEW

Services System Structure

Virginia's public services system includes the Department, the State Mental Health, Mental Retardation, and Substance Abuse Services Board (the State Board), 16 state mental health and mental retardation facilities, and 40 community services boards (CSBs) that may provide services directly or through contracts with private providers. Maps of CSB service areas and the locations of state facilities are contained in Appendix B.

The following diagram outlines the current relationships between these services system components. Solid lines depict a direct operational relationship between the involved entities (e.g., the Department operates the state facilities). Broken lines depict non-operational relationships (e.g., policy direction, contracting, or coordination).



Statutory Authority, Mission, and Responsibilities of the Department and State Board

Title 37.1 of the *Code of Virginia* establishes the Department as the state authority for alcoholism, drug abuse, mental health, and mental retardation services. By statute, the State Board offers policy direction for Virginia's services system.

The mission of the Department's Central Office is to provide leadership and service to improve Virginia's system of quality treatment, habilitation, and prevention services for individuals and their families whose lives are affected by mental illness, mental retardation, or substance use disorders (alcoholism and other drug addiction). It seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals.

Responsibilities of the Department include:

- Providing leadership that promotes strategic partnerships among and between CSBs, state facilities, other services system partners, and the Central Office;
- Providing direct care, treatment, and habilitation services in state mental health and mental retardation facilities (civil and forensic services);
- Supporting the provision of accessible and effective community mental health, mental retardation, and substance abuse treatment and prevention services through a network of CSBs;
- Assuring that public and private mental health, mental retardation, and substance abuse services providers adhere to licensing standards; and
- Protecting the human rights of individuals receiving of mental health, mental retardation, and substance abuse services.

Characteristics of Community Services Boards

Community mental health, mental retardation, and substance abuse services are provided in Virginia through a network of 40 CSBs. CSBs function as:

- The single point of entry into publicly-funded mental health, mental retardation, and substance abuse services, including preadmission screening to access needed state facility services, case management and coordination of services, and predischarge planning for individuals leaving state facilities;
- Service providers, directly and through contracts with other providers;
- Advocates for individuals receiving CSB services and persons in need of services;
- Community educators, organizers, and planners;
- Advisors to the local governments that established them; and
- The primary locus of programmatic and financial accountability.

CSBs exhibit tremendous variety in almost all aspects of their composition, organizational structures, and array of services. Section 37.1-194.1 of the *Code of Virginia* defines three types of CSBs: operating CSBs, administrative policy CSBs, and policy-advisory CSBs with local government departments (LGDs). In several localities, Behavioral Health Authorities (BHAs), established pursuant to Chapter 15 in Title 37.1 of the *Code of Virginia*, may deliver community mental health, mental retardation, and substance abuse services instead of a CSB. In this Plan, the term CSB includes BHA.

Combined Classification of Community Services Boards

CSB Classification	Functions as LGD	Cities and/or Counties Served		Total CSBs
		One	Two or More	
Administrative Policy CSBs[1]	7	7	3	10
LGD with Policy-Advisory CSB	1	1	0	1
Operating CSB[2]	0	2	26	28
Behavioral Health Authority[2]	0	1	0	1
TOTAL CSBs	8	11	29	40

[1] Seven of these CSBs are city or county departments; even though 3 CSBs are not, all use local government employees to staff the CSB and deliver services.

[2] Staff in these 28 CSBs and one BHA are board, rather than local government, employees.

CSBs are not part of the Department. The Department's relationships with all CSBs are based on the community services performance contract. The Department funds, monitors, licenses, regulates, and provides consultation to CSBs.

CSB Mental Health Services

Eligibility for mental health services provided by CSBs is determined by clinical criteria for each local program. Emergency services are available to anyone in the geographic area served by the CSB, while other services are generally targeted to residents of the CSB service area. In FY 2002, 107,351 individuals received CSB mental health services. This represents an unduplicated count of all individuals receiving any mental health services. Numbers of individuals receiving mental health services by core service follows.

Number of Individuals Receiving CSB Services by MH Core Service in FY 2002

Core Service	# Served	Core Service	# Served
Emergency Services	43,966	Alternative Day Support Arrangements	200
Local Inpatient	1,256	TOTAL Day Support Services	8,109
TOTAL Local Inpatient Services	1,256	Highly Intensive Residential	344
Outpatient Services	70,471	Intensive Residential	201
Intensive In-Home	1,914	Supervised Residential	1,193
Case Management	38,599	Supportive Residential	2,866
Assertive Community Treatment	231	Family Support	143
TOTAL Outpatient & Case Management	111,175	TOTAL Residential Services	4,747
Day Treatment/Partial Hospitalization	491	Early Intervention Services	438
Therapeutic Day Treatment - C&A	951	Purchase of Individualized Services*	1,135
Rehabilitation Services	5,601	Special Projects**	5,909
Sheltered Employment Services	67	TOTAL Individuals Served	176,735
Supported/Transitional Employment	754	TOTAL Unduplicated Individuals	107,351
Supported Employment - Group Models	45		

Source: FY 2002 CSB 4th Quarter Performance Reports

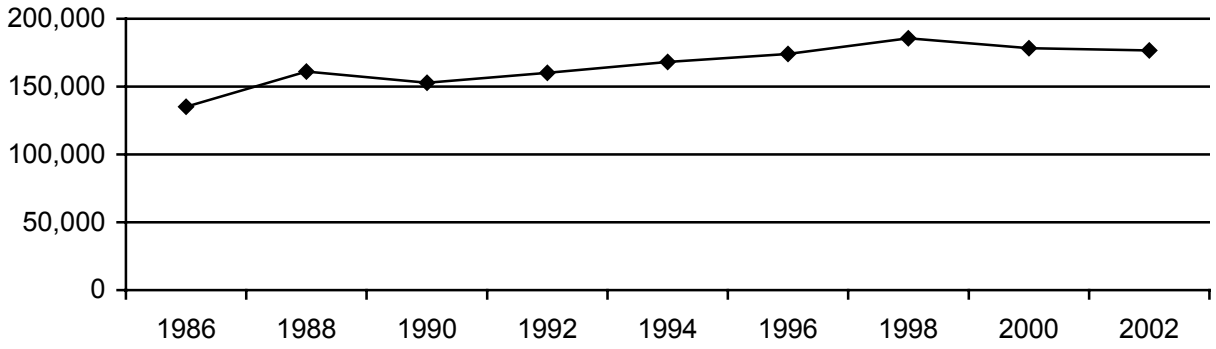
Notes: TOTAL Individuals served are not unduplicated numbers because some individuals receive more than one type of service and sometimes receive services in more than one program area.

*Purchase of Individualized Services (POIS) includes 415 individuals served in the Discharge Assistance Project (DAP) and 720 children and adolescents served in non-CSA Mandated mental health services.

**Special Projects include 1,256 individuals served in Programs of Assertive Community Treatment (PACT), 1,219 individuals served through Assisted Living Facilities (ALF) Projects, and 3,434 individuals served in Community Residential Services.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2002, the numbers of people receiving various CSB mental health services grew from 135,182 to 176,735, an increase of 31 percent. Trends in the numbers of individuals receiving mental health services from CSBs are displayed on the following graph.

Trends in Numbers of Individuals Receiving MH Services From CSBs FY 1986 - FY 2002



These numbers are duplicated counts of individuals receiving services because they are derived from fourth quarter CSB reports that display numbers of people receiving services by core service categories.

CSB Mental Retardation Services

In FY 2002, 24,903 individuals received CSB mental retardation services. This represents an unduplicated count of all individuals receiving any mental retardation services. The number of individuals receiving mental retardation services by core service follows.

Number of Individuals Receiving CSB Services by MR Core Service in FY 2002

Core Service	# Served	Core Service	# Served
Intensive In-Home	89	Highly Intensive Residential	58
Case Management	8,956	Intensive Residential	214
Consumer Monitoring	1,602	Supervised Residential	255
TOTAL Outpatient & Case Management	10,647	Supportive Residential	1,157
Rehabilitation Services	541	Family Support	3,012
Sheltered Employment Services	1,112	TOTAL Residential Services	4,696
Supported/Transitional Employment	1,471	Early Intervention Services	7,720
Supported Employment - Group Models	537	Purchase of Individualized Services*	6,298
Alternative Day Support Arrangements	911	TOTAL Individuals Served	33,933
TOTAL Day Support Services	4,572	TOTAL Unduplicated Individuals	24,903

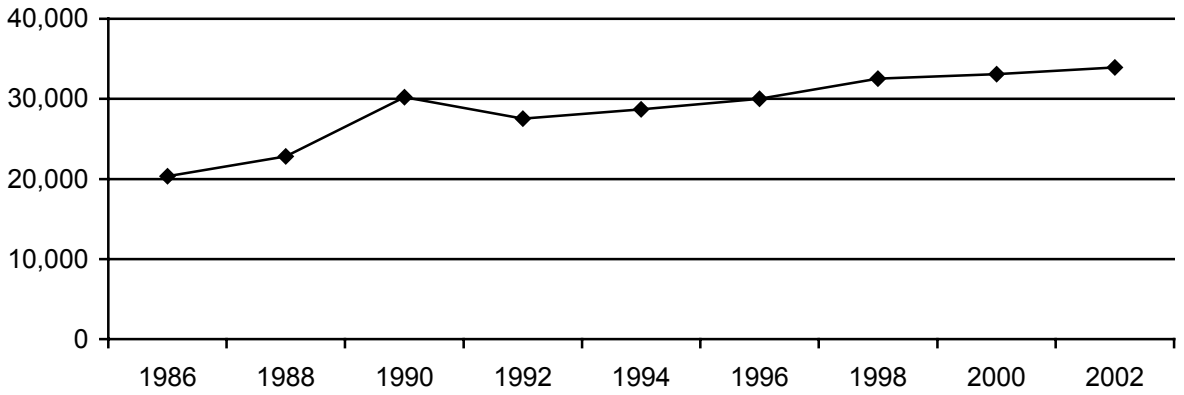
Source: FY 2002 CSB 4th Quarter Performance Reports

Notes: TOTAL Individuals served are not unduplicated numbers because some individuals receive more than one type of service and sometimes receive services in more than one program area.

*Purchases of Individualized Services (POIS) include 5,788 individuals served through MR Waiver POIS and 510 individuals served through Non-MR Waiver POIS (Consumer Support Services) in mental retardation.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2002, the numbers of people receiving various CSB MR services grew from 20,329 to 33,933, or by 67 percent. Trends in the numbers of individuals receiving mental retardation services from CSBs are displayed on the following graph.

Trends in Numbers of Individuals Receiving MR Services From CSBs FY 1986 - FY 2002



These numbers are duplicated counts of individuals receiving mental retardation services because they are derived from fourth quarter CSB reports that display numbers of people receiving services by core service categories.

CSB Substance Abuse Services

In FY 2002, 59,895 individuals received services for substance use disorders from the CSBs. Numbers of individuals receiving substance abuse services by core service follow.

Number of Individuals Receiving CSB SA Services by Service in FY 2002

Core Service	# Served	Core Service	# Served
Emergency Services	8,843	Highly Intensive Residential	5,342
Local Inpatient	37	Jail-Based Habilitation	1,084
Community Hospital-Based Detox	236	Intensive Residential	4,028
TOTAL Local Inpatient Services	273	Supervised Residential	309
Outpatient Services	43,308	Supportive Residential	1,023
Motivational Treatment	1,187	Family Support	159
Case Management	16,228	TOTAL Residential Services	11,945
Methadone Detoxification	623	Early Intervention Services	2,103
Opioid Replacement Therapy	2,024	Special Projects*	3,330
TOTAL Outpatient & Case Management	63,370	TOTAL Individuals Served	91,904
Day Treatment/Partial Hospitalization	2,006	TOTAL Unduplicated Individuals	59,895
Alternative Day Support Arrangements	34		
TOTAL Day Support Services	2,040		

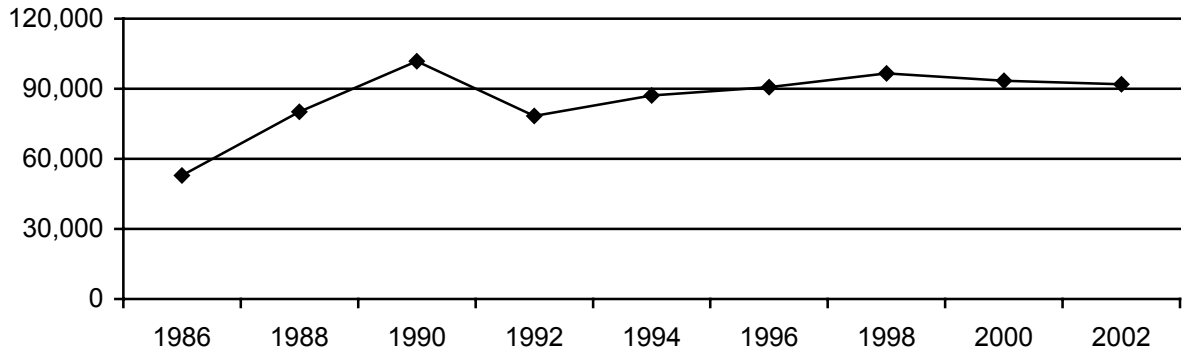
Source: FY 2002 CSB 4th Quarter Performance Reports

Notes: TOTAL Individuals served are not unduplicated numbers because some individuals receive more than one type of service and sometimes receive services in more than one program area.

*Special Projects include 2,163 individuals served through the Substance Abuse State Facility Diversion Project, 120 individuals served in Community-Based Perinatal Treatment for Women with Alcohol or Other Drug Addictions, and 1,047 individuals served in Substance Abuse Jail Services.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2002, the numbers of people receiving various CSB substance abuse services grew from 52,942 to 91,904, an increase of 74 percent. Trends in the numbers of individuals receiving substance abuse services from CSBs are displayed on the following graph.

Trends in Numbers of Individuals Receiving SA Services From CSBs FY 1986 - FY 2002



These numbers are duplicated counts of individuals receiving services because they are derived from fourth quarter CSB reports that display numbers of people receiving services by core service categories.

In summary, CSBs provided mental health, mental retardation, and substance abuse services to 192,149 individuals in FY 2002. Appendix C contains detailed information on CSB service utilization trends, levels of functioning or disability for individuals served by CSBs in FY 2002, and condensed core services definitions.

Characteristics of State Mental Health and Mental Retardation Facilities

State Mental Health Facilities

State mental health facilities provide highly structured intensive inpatient treatment services, including a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary services. Specialized programs are provided for geriatric, child and adolescent, and forensic patients. The Joint Commission for Accreditation of Healthcare Organizations (JACHO) has accredited all state mental health facilities. The Commonwealth licenses child and adolescent services provided by the Southwestern Virginia Mental Health Institute and the Commonwealth Center for Children and Adolescents (CCCA) under the CORE regulations for residential children's services.

Operating (staffed) bed capacities for each state mental health facility follow.

Mental Health Facility Operating Capacities – June 12, 2003

MH Facility	# Beds	MH Facility	# Beds	MH Facility	# Beds
Catawba Hospital	110	Eastern State Hospital	529	Southern VA MHI	72
Central State Hospital	320	Northern VA. MHI	127	Southwestern VA MHI	176
CCCA	48	Piedmont Geriatric	135	Western State Hospital	281
TOTAL OPERATING CAPACITY (BEDS)					1,798

Note: The Hiram W. Davis Medical Center, with an operating capacity of 74 beds, is not included in this table or the next, since it is primarily a medical and skilled nursing facility.

A new behavioral rehabilitation facility opened in October 2003. This facility provides individualized treatment services in a secure facility to individuals who are civilly committed as sexually violent predators.

In FY 2003, there were 5,946 admissions to and 6,008 separations from the nine state mental health facilities, excluding the Hiram Davis Medical Center. The average daily census by facility follows:

Mental Health Facility Average Daily Census (ADC) – FY 2003

MH Facility	ADC	MH Facility	ADC	MH Facility	ADC
Catawba Hospital	93	Eastern State Hospital	486	Southern VA MHI	76
Central State Hospital	280	Northern VA. MHI	120	Southwestern VA MHI	147
CCCA	35	Piedmont Geriatric	122	Western State Hospital	252
TOTAL STATE MH FACILITY AVERAGE DAILY CENSUS					1,609

Source: PRAIS, ESH provided data for June and July 2003.

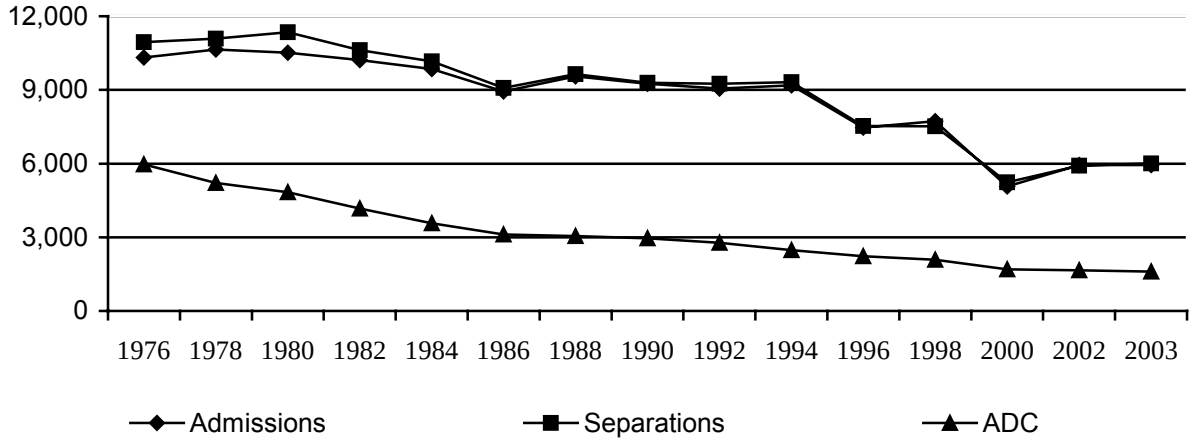
Between FY 1976 – FY 1996, the average daily census at state mental health facilities declined by 3,745, or 63 percent (from 5,967 to 2,222). Between FY 1996 – FY 2003, the average daily census declined by 28 percent (from 2,222 to 1,609).

Between FY 1996 – FY 2003, admissions declined by 26 percent (from 7,468 to 5,946). After a significant decline in the number of admissions between FY 1998 – FY 2000 (2,362), the number of admissions increased by 154 between FY 2000-FY 2001, by 713 between FY 2001 - FY 2002 and by 10 between FY 2002 - FY 2003.

Between FY 1996 – FY 2003, separations declined by 20 percent (from 7,529 to 6,008). Separations include normal discharges, discharges against medical advice, transfers, and deaths of registered patients. After a substantial decline between FY 1998 – FY 2001 (2,346), the number of separations increased by 738 between FY 2001 - FY 2002 and by 93 between FY 2002 - FY 2003.

Admission, separation, and average daily census trends (FY 1976 - FY 2003) for state mental health facilities, excluding the Hiram Davis Medical Center, follow.

MH Facility Admissions, Separations, and Average Daily Census (ADC) Trends: FY 1986 - FY 2003.



Note: Includes the Virginia Treatment Center for Children through FY 1991, when it transferred to MCV.

State Mental Retardation Training Centers

State mental retardation training centers provide highly structured habilitation services, including residential care and training in areas such as language, self-care, independent living, socialization, academic skills, and motor development. All training centers are certified by the U.S. Centers for Medicare and Medicaid (CMS) as meeting Medicaid standards of quality. Each training center operates as an Intermediate Care Facility for the Mentally Retarded (ICF/MR). In addition, Central Virginia Training Center provides skilled nursing services.

Admission to a state mental retardation training center for individuals with mental retardation is governed by §37.1-65.1 of the *Code of Virginia* (regular admission judicial certification process) and by §37.1-65.2 and regulations promulgated under that statute (emergency and respite admission up to 21 days). Applicants for admission to state training centers must have a diagnosis of mental retardation and have deficits in at least two of seven areas of adaptive functioning. Applications for admission are made through the CSB in the locality where the applicant resides. Applicants who meet the criteria for admission to an ICF/MR must be offered the choice of ICF/MR or community-based Medicaid MR Waiver services.

Operating (staffed) bed capacities for each state mental retardation training center follow.

Mental Retardation Training Center Operating Capacities–June 12, 2003

MR Training Center	# Beds	MR Training Center	# Beds
Central Virginia Training Center	635	Southside Virginia Training Center	415
Northern Virginia Training Center	200	Southwestern Virginia Training Center	223
Southeastern Virginia Training Center	200	TOTAL OPERATING CAPACITY (BEDS)	1,673

In FY 2003, there were 95 admissions to and 132 separations from the five state mental retardation training centers. The average daily census by facility follows:

Mental Retardation Training Center Average Daily Census (ADC)–FY 2003

MR Training Center	ADC	MR Training Center	ADC
Central Virginia Training Center	606	Southside Virginia Training Center	387
Northern Virginia Training Center	185	Southwestern Virginia Training Center	212
Southeastern Virginia Training Center	191	TOTAL AVERAGE DAILY CENSUS	1,581

Source: PRAIS, SEVTC provided data for June and July 2003.

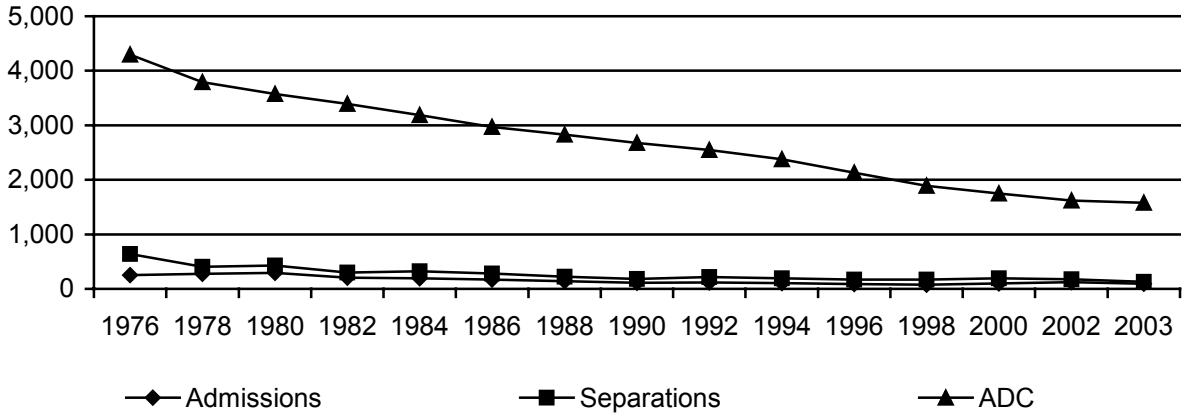
Between FY 1976 – FY 1996, the average daily census at state training centers declined by 2,161, or 51 percent (from 4,293 to 2,132). Between FY 1996 – FY 2003, the average daily census declined by 26 percent (from 2,132 to 1,581). ADC declined every year.

Between FY 1996 – FY 2003, training center admissions increased by 10 percent (from 87 to 95). During this period, admissions decreased by 9 between FY1996 – FY 1998, then increased by 23 between FY 1998 – FY 2000 and 21 between FY 2000 – FY 2002, before decreasing by 27 between FY 2002 – FY 2003.

Between FY 1996 – FY 2003, training center separations declined by 41 percent (from 223 to 132). During this period, the number of separations first decreased by 53 between FY1996 – FY 1998, then increased by 24 between FY 1998 – FY 2000, before decreasing by 17 between FY 2000 – FY 2002 and by 45 between FY 2002 – FY 2003.

Admission, separation, and average daily census trends (FY 1976 – FY 2003) for state mental retardation facilities follow:

MR Facility Admissions, Separations, and Average Daily Census (ADC) Trends: FY 1986 - FY 2003

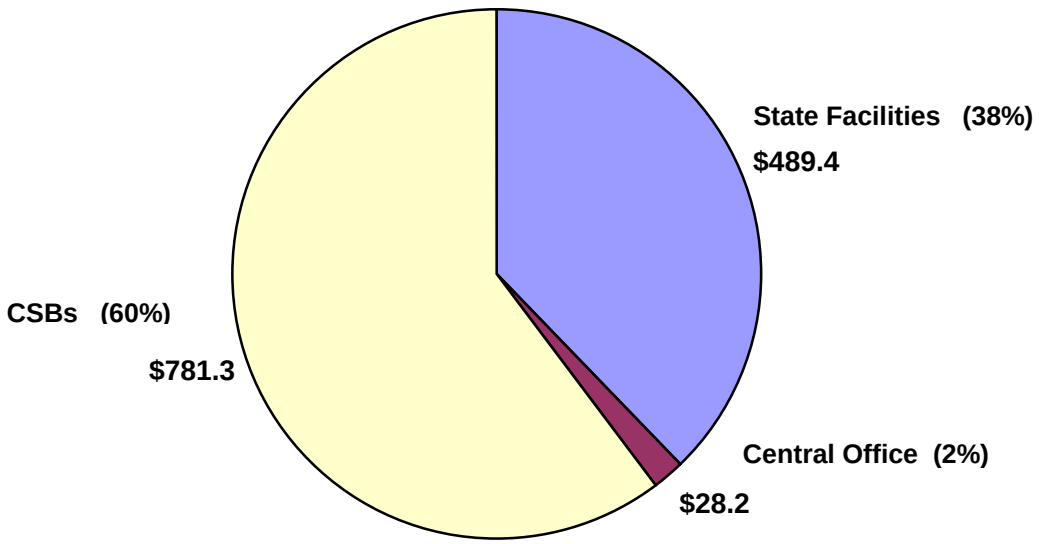


Appendix D contains detailed state facility utilization information, including the numbers served, average daily census, admissions, separations, and utilization by CSB.

Services System Funding

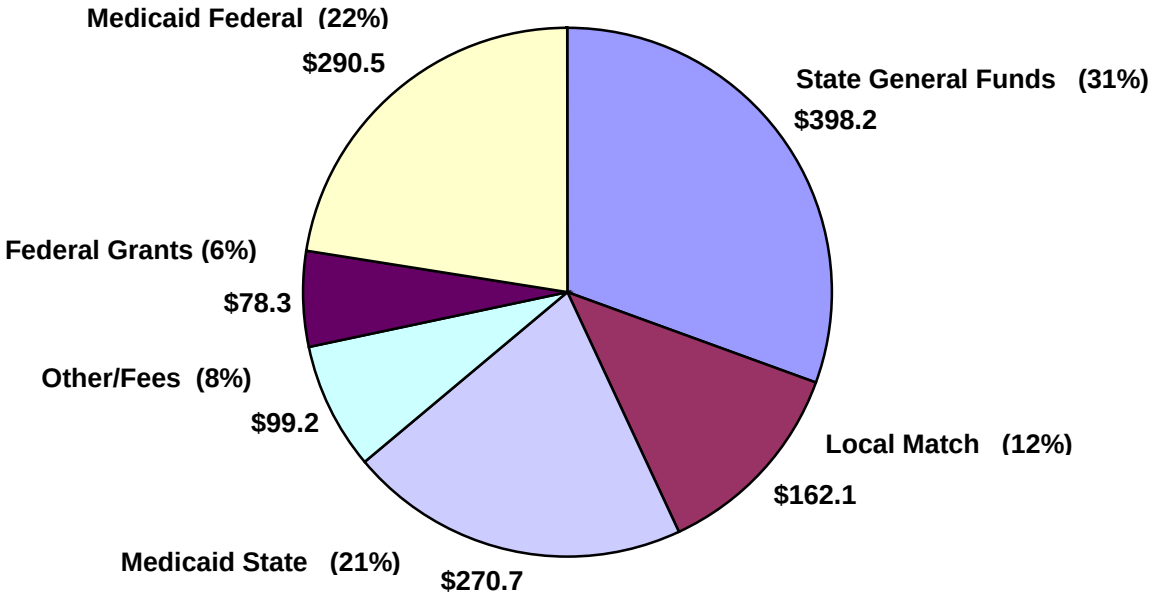
Charts depicting the services system's total resources for **FY 2003** from **all sources** (rounded and in millions), including the Department's final adjusted appropriation, local matching funds, all fees, and Medicaid Mental Retardation Home and Community-Based Waiver (MR Waiver) payments to private vendors, follow.

FY 2003 Total Services System Funding
$1.299 Billion



Dollars Above Are in Millions

FY 2003 Total Services System Funding
$1.299 Billion

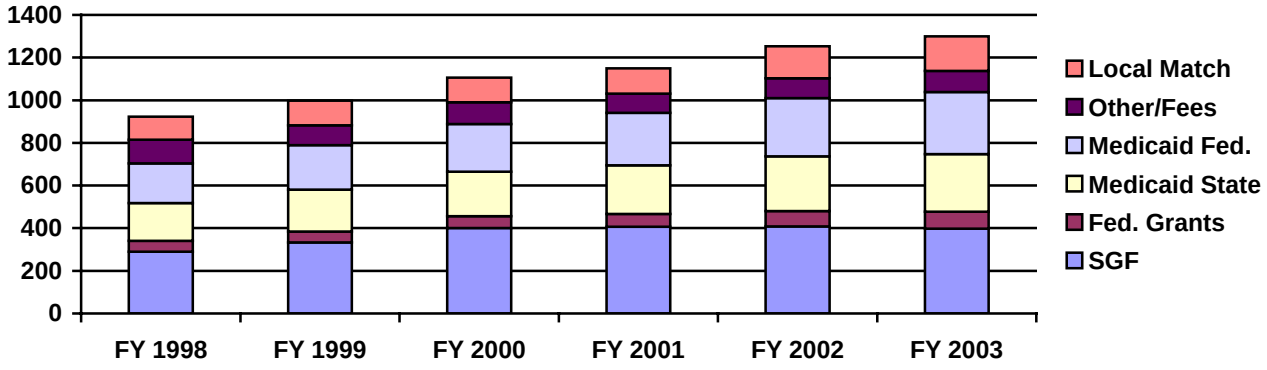


Dollars Above Are in Millions

Funding Trends

Between FY 1998 and FY 2003, total services system funding grew by 40 percent from $923.2 million to $1.299 billion. The following table depicts funding by source (in millions) for this time period.

	FY 1998	FY 1999	FY 2000	FY2001	FY 2002	FY 2003
State General Funds	290.3	332.8	399.9	406.5	408.2	398.2
Federal Grants	51.0	51.3	56.2	59.8	72.2	78.3
Medicaid - State	176.0	196.3	209.0	228.4	256.9	270.7
Medicaid - Federal	186.7	209.1	223.2	245.5	273.3	290.5
Other/Fees	111.3	93.2	102.0	90.6	92.8	99.2
Local Match	107.9	115.9	115.9	118.9	149.3	162.1
Total	$923.2	$998.6	$1,106.3	$1,149.7	$1,252.7	$1,299.0



IV. CURRENT AND FUTURE SERVICE NEEDS

CSB Waiting Lists

The following table displays the number of Virginians who were on CSB waiting lists for community mental health, mental retardation, and substance abuse services on April 11, 2003 and on the August 2003 MR Waiver urgent and non-urgent waiting lists.

Numbers of Individuals on CSB Waiting Lists for Mental Health, Mental Retardation, and Substance Abuse Services by Population

Population	Numbers Who ARE Receiving Some CSB Services	Numbers Who Are NOT Receiving Any CSB Services	Total Numbers on CSB Waiting Lists
CSB Mental Health Waiting List Count			
Adults with Serious Mental Illnesses	4,327	703	5,030
Children & Adolescents With or At Risk of Serious Emotional Disturbance	994	320	1,314
Total MH	5,321	1,023	6,344
CSB Mental Retardation Waiting List Count			
CSB Non-Waiver Services	2,320	336	2,656
MR Waiver Urgent Waiting List	--	--	1,176
MR Waiver Non-Urgent Waiting List	--	--	1,259
CSB Substance Abuse Waiting List Count			
Adults with Substance Dependence or Abuse	2,204	793	2,997
Adolescents with Substance Dependence or Abuse	211	76	287
Total SA	2,415	869	3,284
Total CSB Mental Health, Mental Retardation, and Substance Abuse Services Waiting List Count			
Grand Total on All CSB Waiting Lists	10,056	2,228	12,284
MR Waiver Waiting Lists	--	--	2,435

To be included on the CSB waiting list for CSB services, an individual had to have sought the service and been assessed by the CSB as needing that service on April 11, 2003. CSB staff also reviewed their active cases to identify individuals on their active caseloads who were not receiving the amounts or types of services that they needed. This point-in-time methodology for documenting unmet service demand is conservative because it does not identify the number of persons who needed services over the course of a year. Appendix E contains numbers of individuals on waiting lists for mental health, mental retardation, and substance abuse services by CSB.

The MR Waiver Monthly Report for August 2003 reported 1,176 individuals on the “urgent” waiting list, which identifies applicants at serious risk of institutionalization, abuse or neglect or whose family is unable to care for them appropriately due to advanced age or disability. An additional 1,259 individuals are on the “non-urgent” waiting list, many of whom are leaving school systems with no follow up services or are currently receiving Comprehensive Services

Act funding for services that will end in a year or less. Appendix F contains the number of individuals on the August 2003 Medicaid Mental Retardation Home and Community-Based Waiver "urgent" and "non-urgent" waiting lists by CSB.

State Mental Health and Mental Retardation Facility Discharge Lists

There are currently 109 patients in state mental health facilities whose discharges have been delayed due to extraordinary barriers and 173 residents of state mental retardation training centers who, with their legally authorized representative or family member, have chosen to continue their training and habilitation in the community instead of a state training center.

Students Receiving Special Education Services

According to the Virginia Department of Education, based on counts made on December 1, 2001, there were 14,182 students with a primary disability (as defined by special education law) of emotional disturbance and 13,425 students with mental retardation receiving special education services. Included in this count were students in a local school division, in either of the two schools for the deaf and the blind, in a state mental health or mental retardation facility, and in a private day or residential placement made by the school division or Comprehensive Services Act team. These numbers do not include children who are not receiving special education services. Also not included are students in private placements made by the parents or children educated by the Department of Correctional Education. As these students age out of special education services, many will require community-based treatment or habilitation services to maintain the skills they learned in special education.

Projected Population Changes Through 2010 and Expected Future Service Needs

Individuals With Mental Illnesses

Changes in the mental health population over the next six years are likely to mirror those in the overall United States population. As the population ages, people with mental illness may also begin to experience complications from a variety of physical illnesses. Community mental health programs should prepare for these changes by analyzing their service arrays for their appropriateness for an older population. CSBs are likely to see an increasing number of individuals with mental illness who will require mental health supports to enable them to reside in a nursing home or assisted living facility.

The aging population also will require some changes in the state's Medicaid benefit package. Medically fragile individuals who also have a mental illness will need services over and above what nursing homes, assisted living facilities and other residential setting may be able to provide. To avoid over reliance on state inpatient care for these individuals, it will be important to create more flexible Medicaid reimbursement for community-based services that are appropriate for older individuals with mental illness.

Individuals with Mental Retardation

Growth in demand for mental retardation services is expected to result from several factors:

- General population growth in Virginia, which is expected to continue through 2010;
- Increased ability of technology to assess and treat severe disabilities, leading to a greater number of individuals identified and higher survival rates; and
- Increased demands placed upon Virginia due to the significant presence of military personnel who have family members with disabilities and who choose to live in Virginia in order to receive services that are often provided by state and local programs.

The service system's increasing ability to assess mental retardation and co-occurring mental or physical disabilities, including mental illness, autism, and severe physical disabilities, also will challenge a system that is already deficient in addressing support and treatment needs of these

groups. Greater numbers of children currently coming through Virginia's school systems are being identified as having autism, both with and without a co-occurring condition of mental retardation. This increase reflects a national trend that some label an "epidemic."

Additionally, increasing numbers of aging people with mental retardation are developing other health problems, particularly Alzheimer's disease, and will require specialized services and supports to address these health problems. The Department and the services system must look at new models of community-based services as alternatives to increased institutionalization.

Individuals With Substance Use Disorders

Changes in demand for substance abuse services over the next six years and beyond are likely for two population groups in particular: youth and their families and older Virginians. A review of 2002 National Household Survey on Drug Use and Health (formerly the National Household Survey on Drug Use) data suggests that the use of illicit substances (e.g., cocaine and heroin) and the non-medical use of prescription pain relievers and stimulants, particularly among youths and young adults, are increasing. Alcohol use has been increasing steadily since 1990, with youth under age 18 accounting for much of the increase. Adolescent use nearly doubled, from 2.2 million in 1990 to 4.1 million in 2000, with gender distribution about equal. According to the National Center on Addiction and Substance Abuse at Columbia University (NCASA), alcohol is the primary drug used by children and teens in America: more than 31 percent report binge drinking at least once a month. (*Teen Tipplers: America's Underage Drinking Epidemic*, National Center on Addiction and Substance Abuse at Columbia University, 2002). According to a 2003 report from the National Research Council and the Institute of Medicine of the National Academies of Science, more young people drink alcohol than use other drugs or smoke tobacco, costing the nation approximately $53 billion annually in losses related to traffic fatalities, violent crime, and other behaviors that threaten the well-being of America's youth.

As Virginia's population ages, there will be increasing demand for specialized substance abuse services for older persons with substance use disorders. If abuse of alcohol and legal drugs among older Virginians were to continue at the same rate as their U.S. counterparts (17 percent), demand for specialized treatment services could be 1.5 times greater in 2030 because of population growth. (Gfoerer and Epstein, 1999, in DASIS 2001)

The Department must develop programs and services that are specifically designed to attract, motivate, and retain youth and families, to recognize the needs of older populations, and to utilize evidence-based practices, workforce development, and collaboration with other agencies and organizations that focus on services to youth and older persons

Sexually Violent Predators

Many individuals identified by the Department of Corrections as being in the pool of inmates convicted of a predicate crime (e.g., rape, forcible sodomy, object sexual penetration, or aggravated sexually battery when the victim is under 13) and assessed to have a diagnosis and documentation of a mental abnormality or personality will not meet the level of risk required for civil commitment to the Center for Behavioral Rehabilitation, a secure facility operated by the Department to treat sexually violent predators. Assuming that 8 percent of individuals in the pool will meet the level of risk and be civilly committed to this program, the projected Center for Behavioral Rehabilitation census will be 27 by June 1, 2004. This census will continue to increase and, based on this estimate and the experience of other states with similar programs, could reach between 125 and 150 individuals by 2010. The Department does not currently have the capacity to serve this number of individuals in a secure facility.

Additionally, some individuals in this pool may be placed by the Circuit Court in community-based conditional release programs. Necessary programs and services to serve this population also would need to be developed.

VI. CRITICAL ISSUES AND STRATEGIC RESPONSES

Restructuring Virginia's System of Care

Restructuring Goals and Guiding Principles

In December 2002, Governor Warner proposed the first stage of a multi-year vision to fundamentally change how mental health, mental retardation, and substance abuse services are delivered and managed in Virginia. This vision would responsibly reduce, through grass-roots strategic planning, the Commonwealth's reliance on its state facilities for services that could be more appropriately provided in the community.

Virginia must achieve a better balance of community and state facility services. This is evident in State Profile Information collected by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute. In FY 2001, Virginia ranked 7th among the states in per capita expenditures for state inpatient mental health services and 41st in per capita expenditures for community mental health services. Virginia's per capita expenditures for community services were less than half the national per capita expenditures. The following table compares Virginia and national per capita funding for state inpatient and community mental health services in FY 2001.

FY 2001	Rank	Virginia Per Capita Expenditures	National Per Capita Expenditures
Virginia MH Inpatient Expenditures	7	$38.80	$25.58
Virginia MH Community Expenditures	41	$22.74	$53.46

The existing system of state facilities and community services must be restructured to more appropriately respond to the needs of individuals with serious disabilities, support recovery, and expand choice and self-direction. The long-term goal of restructuring Virginia's services system is to achieve a more comprehensive and fully developed system of community-based care that:

- Provides quality services closer to where people live so individuals receiving services can maintain family and community relationships and achieve the highest possible level of participation in work and other aspects of community life;
- Expands the types of services available in the community, while maintaining state facility services as an essential component of the services system;
- Facilitates local and regional management and "ownership" of community and state facility services; and
- Complies with the U.S. Supreme Court decision in the case of Olmstead v. L.C., 119 S. Ct 2176 (1999), which held that states are required under Title II of the Americans with Disabilities Act to provide services in the most integrated setting appropriated needs of qualified individuals with disabilities (see page 56).

Guiding principles for restructuring Virginia's system of care are listed below.

Focus First on Individuals Receiving Services – The needs of individuals receiving services should be at the center of this planning process.

Commitment to Staff – The services system should be committed to the retention, redeployment, training, and development of services system staff.

Community-Based – With Safety Net – The services system should be structured to provide, manage, and coordinate services as close to the individual's home as possible, with the state assuring a safety net for individuals who cannot be served in the community.

Change Incentives – Incentives should be created or changed to promote a community-based system of care that delivers the highest possible quality of services.

Continuum of Care – The system should provide a continuum of care where the severity of an individual's illness or disability determines the most appropriate location, level, type, and intensity of care.

Reinvestment of Resources – Services system resources should be redirected and reinvested to minimize reliance on and promote the effective use of inpatient services. However, the cost of inpatient services should not be shifted to local governments.

Flexibility and Choice – The services system should be flexible and seamless, allowing for the greatest amount of individual choice, and be able to respond to changing population and individual service recipient needs.

Maximize Funds – The services system should be structured to maximize all available public funds, especially Medicaid, and make the most efficient and effective use of these resources.

Financial Viability – The long-term financial viability of services should be incorporated in plans for restructuring.

The Governor proposed and the 2003 General Assembly passed Appropriation Act language directing the Department to implement three regional reinvestment projects. These projects are the products of collaborative CSB and state facility planning in Central Virginia, Eastern Virginia, and Northwestern Virginia. Each is tailored to the region's needs and to its public and private services structure. While intended to change existing patterns of state mental health facility use, none would close a state facility or convert it to another use. Rather, they use different strategies for transferring certain facility resources into the community to expand community-based care and treatment for individuals who would otherwise require state facility services. These projects are summarized below.

Central Region Project: This project will close two civil wards at Central State Hospital by:

- Establishing a regional 24/7 supervised residential dual diagnosis (MI/SA) crisis stabilization/detoxification services;
- Purchasing regional specialized nursing home beds;
- Establishing a regional utilization review system; and
- Strengthening the region's existing hospital census management process.

Eastern Region Project: This project focuses on the carefully phased closure of acute care services at Eastern State Hospital, starting with 43 of the 86 acute admission beds in FY 2004. The region has established a regional hospital census management process through which it will purchase acute psychiatric care in the community.

Northwestern Region Project: This project with close two inpatient units at Western State Hospital by:

- Transferring long-term patients who have dual diagnoses of mental illness and mental retardation into community Intermediate Care Facilities/Mental Retardation (ICF/MR) programs, with CSBs providing psychiatric services and Western State Hospital providing psychological consultation to the ICF/MR residents; and
- Discharging long-term patients to the community with individualized wrap-around services and community placements supported by discharge assistance funds and the purchase of acute care beds in the community.

The success of these reinvestment projects is dependent upon the extent to which they:

- Improve the lives of individuals receiving services and their families who have been affected by the projects;

- Expand the array and amount of community services for individuals who otherwise would require state facility services;
- Transition state facility staff affected by the projects to comparable positions within the services system;
- Involve services system partners in ongoing collaborative project planning; and
- Retain current total funds in the services system by reinvesting state facility resources into community services.

The Department is working with the project leadership in each region to develop measures to document project performance. This will include core measures for all projects and project-specific measures that reflect the unique characteristics of each project. At a minimum, these measures should reflect trends of increased use of community-based resources, a decreased reliance on state facility beds, and continuity of post-discharge care. Each region will report its performance results periodically on a regular schedule.

Regional Reinvestment Initiatives and Restructuring Planning Proposals

In November 2002, the Department proposed a regional planning process to explore opportunities with all interested partners to achieve a more fully community-based system of care. The Department provided final guidance for the first Regional Partnership Report to each region in March 2003. Seven regions generally aligned with the state mental health facility service areas initiated Regional Partnership planning processes. In these regional processes, new opportunities for communication among the many services system partners have emerged. Regions began to look differently at how services and supports might be organized to achieve a more community-focused system of care. Regions explored opportunities for establishing new partnerships with private providers and interested citizens. Through the three Reinvestment Projects and the Partnership Planning processes, the regions have already successfully changed how and where services are being delivered. Examples of these changes follow:

- A model has been implemented that categorizes inpatient treatment levels according to acuity, complexity, and expected length of staff. This model could be used by state mental health facilities and private psychiatric hospitals to appropriately triage and refer individuals to inpatient settings.
- A new regional MR/MI program, located at the Southwestern Virginia Training Center and administered through a collaborative relationship with the involved CSBs will provide specialized services to individuals who otherwise would require inpatient services.
- New structures to implement shared CSB and state facility ownership of the responsibility for managing all publicly funded inpatient beds, ensuring that the appropriate level of care is provided at the right time and in the right location for each individual, have been developed.
- New service alternatives to inpatient care, including a regional supervised residential program providing crisis stabilization/detoxification services to individuals with co-occurring mental illness and drug use disorders and regional specialized nursing care services, are being developed.

In their Regional Partnership Plans, the regions have laid the groundwork for realizing the vision of a more comprehensive community-based system of care. Key themes in these plans include:

- Expanding existing community services capacity;
- Developing new service alternatives;
- Sharing and blending of state facility and community services and staff resources; and
- Implementing regional utilization management of inpatient resources through CSB, state facility, and private provider partnerships.

The Regional Partnership Plans also speak to the need for state-level actions to address forensic/NGRI issues and Medicaid policy and regulatory, funding, covered service areas.

The following summaries outline the progress of each Reinvestment Initiative, where applicable, and the results of each region's Partnership Planning process, including recommendations provided to the Department for regional and state-level actions.

Catawba Regional Partnership

The goal of the Catawba Regional Partnership is to ensure that residents of its communities are served more compassionately and effectively. The system of care addressed in this Partnership Planning includes Catawba Hospital, Blue Ridge Behavioral Healthcare, Alleghany-Highlands CSB, and private providers in the region that have close linkages to the public mental health system, particularly Carilion Health System and HCA Lewis-Gale Hospital. In addition to these providers, members of the Partnership Leadership Committee include representatives from the Roanoke chapter of the National Alliance for the Mentally Ill and the Mental Health Association of the Roanoke Valley. Meetings with services system partners were held on July 14, 2003 and July 17, 2003. Eight workgroups were established to address the following priority areas identified by the Regional Partnership.

- Treatment Process Across the Continuum of Care
- Provision of Psychosocial Rehabilitation and Day Treatment Services
- Development of Transitional Housing Options
- Development of a PACT Program for Alleghany-Highlands CSB
- Physician Resource Utilization
- Centralized Pharmacy Services
- Budget and Cost Revenue Analysis
- Contract Development.

These workgroups found that there were significant overlaps as well as gaps in the services provided by current treatment entities. They also found significant barriers in moving from one component of the treatment continuum to another, increasing the likelihood that individuals would not follow-through with sometimes-vital services. Particular attention was given to the interface between Catawba Hospital and the two CSBs it serves, especially with respect to admissions and discharges.

The Regional Partnership is proposing the following strategies to provide a more efficient, effective, and accessible system of care that includes public and private sector treatment providers without sacrificing inpatient or outpatient treatment capacities.

- Develop a common medication formulary among all entities that participate in the treatment continuum. Discharge plans must be centered and focused on individuals receiving services, with these individuals and psychiatrists agreeing on what medications will be prescribed and the availability of medications established.
- Develop overarching, long-range treatment goals for and with individuals receiving services. Although the needs of and priorities for treating these individuals may vary over time, a consistency in treatment planning across treatment settings is essential.
- Develop interagency treatment plans and improve sharing of treatment planning information across agencies to make treatment more effective, efficient, and consistent.
- Improve the process of linking individuals receiving services in hospital settings to CSB services by assigning these individuals to CSB teams and having their CSB case managers meet with them prior to their discharge from the hospital.

- Encourage family members to become active members of the treatment team whenever possible, by expanding service times to include evenings and providing education to all families about serious mental illness and its impact on the individual and the family.
- Establish a new psychosocial rehabilitation/day treatment "Bridges Program" to be provided in the Catawba Treatment Mall for recently discharged individuals to ease their transition back into a community-based living situation. This program would allow continued support in a familiar setting and with familiar providers until individuals could ultimately transition to a community-based psychosocial treatment program.
- Utilize current CSB and hospital-based clinicians in the provision of treatment across treatment settings.
- Expand existing utilization review processes that involve Catawba Hospital and Blue Ridge Behavioral Healthcare and medical staff peer review to incorporate staff from all treatment settings, such as emergency room physicians and private service providers.
- Develop a "Roadmap to the Community," which could be used by individuals, families, and treatment providers seeking information on available services, how to access these services, pertinent contact and logistical information, and other resources, such as entitlement benefits, housing, primary healthcare, and indigent pharmacy programs.
- Develop Transitional Housing, which will offer step-down or step-up residential services to adults who have been recently discharged from Catawba or who are at risk of inpatient admission. Such services do not currently exist in the region and would require specialized funding.
- Develop a pilot program with 25 participants to demonstrate the effectiveness of specialized treatment services across public and private treatment settings for adults with co-occurring serious mental illness and substance use disorders.
- Develop a regional pharmacy to provide for quicker response to medication needs and increase efficiencies in the provision of pharmacy services. This would require the transfer of current and future funds allocated for the region from the Department's Hiram Davis Aftercare Pharmacy.
- Expand the region's array of community-based emergency and crisis services to give individuals treatment options other than inpatient treatment, particularly:
  - Crisis services provided in a setting other than a hospital-based emergency room,
  - Rapid assessment and referral (e.g., through a central assessment/resource/referral unit for crisis services),
  - An accessible shelter for homeless individuals,
  - Next day access to psychiatric evaluation and case management services and to counseling and medications, and
  - Other evidence-based interventions such as peer-to-peer counseling, crisis stabilization, and development of a "warm line" for non-emergent support.
- Enter into a Partnership Memorandum of Agreement (MOA) with specific contractual language regarding service planning and billing. This MOA would include the purpose of the regional partnership; sections that address the roles and responsibilities of the partners; the vision and core values of the partnership; individual, family member, and advocacy group involvement and participation; and system leadership, communications, accountability, and quality improvement issues. Separate annexes or addenda are envisioned to define the scope, roles and responsibilities, and operational procedures for specific partnership activities (e.g., physician resource management, pharmacy services, transitional housing services, treatment process, and psychosocial rehabilitation).
- Continue to collect information regarding the value and cost of restructuring services to demonstrate "in hard dollars" the impact of the Partnership's restructuring plan.

To support these strategies, the Regional Partnership has recommended the following state-level actions for consideration by the Department.

- Review and adjust regulations, as necessary, to allow community and state facility staff to work interchangeably and to provide services that are reimbursable by DMAS.
- License the Catawba Treatment Mall for individuals receiving community-based or seek a variance from DMAS excusing this program from this type of license. Currently, the Medicaid State Plan Option does not allow state facility-based programs to bill for Medicaid.
- Seek new funds for the transitional housing proposal for two separate houses, one in Roanoke and one in Catawba, each accommodating 6 to 8 residents.
- Transfer funds from the Hiram Davis Aftercare Pharmacy for individuals in the Alleghany-Highlands and Blue Ridge service areas to the regional pharmacy budget annually under a contract that includes an escalator clause insuring continued increases that allow the pharmacy to remain viable. The region projects that once the pharmacy is fully operational, a $3.75 prescription fee, Medicaid reimbursement, and other operating efficiencies could offset some continuing costs.

The organization of a Regional Child and Family Partnership Project is currently underway.

Central Regional Partnership

To date, the Central Regional Partnership has focused its restructuring activity on the implementation of its Regional Reinvestment Project and has achieved a number of successes. The Central Region covers Chesterfield CSB, Crossroads Services Board, District 19 CSB, Goochland-Powhatan Community Services, Hanover County CSB, Henrico Area Mental Health and Retardation Services, Richmond Behavioral Health Authority, and Central State Hospital (CSH). CSH closed one 15-bed unit in June 2003. A second unit was closed in August 2003, almost two months ahead of schedule. With each closure, CSH transferred $1.4 million (annualized) to the Richmond Behavioral Authority, the region's fiscal agent.

The funds from these unit closures will be used to address the Region's planned and budgeted regional and local reinvestment costs. A comprehensive model Reinvestment Memorandum of Agreement (MOA) has been developed with the Department. The Region has hired a Reinvestment Project Manager, who started on September 1, 2003.

The Regional Consortium Request for Proposals (RFP) Committee has finalized the RFP process, and negotiations are continuing with a selected vendor to establish a regional 24/7 supervised residential crisis stabilization/detox program with services to be available in October. In addition, the Region is following up with potential providers of regional specialized nursing care services for identified CSH patients in need of such care. Initial contracting will be on a purchase of service basis. The Region is continuing to develop and expand local services, such as intensive case management, psychosocial rehabilitation, assertive community treatment, intensive supportive residential, and specialized assisted living with a day program.

Last year, the Central Region formed a Regional Partnership Planning Steering Committee that is composed of three CSB Executive Directors, one CSB mental health director, one CSB mental retardation director, one CSB substance abuse director, one MR advocate, one MH advocate, one SA advocate, the Directors of Central State Hospital and Southside Virginia Training Center, one representative from local government, and one representative from private hospitals. This Committee has steered the region's restructuring planning effort.

The Committee created a survey that was designed to understand the respondent's perspective on priority populations and service gaps. This survey was sent to an extensive list of services system partners. The Committee held six focus groups and two public hearings in September 2003 to collect information on priority populations and services gaps. The focus groups included mental health, mental retardation, substance abuse, local government, hospital/ provider, and criminal/juvenile justice discussions. They used resource information already

secured through a regional survey of individuals receiving services and services gaps, a demographics/prevalence study, and a report provided by the Central Virginia Health Planning Agency.

Eastern Regional Partnership

To date, the Eastern Region (HPR V) has focused its restructuring activities on the implementation of its Regional Reinvestment Project. The Eastern Region covers the Chesapeake CSB, Colonial Services Board, Eastern Shore CSB, Hampton-Newport News CSB, Middle Peninsula-Northern Neck CSB, Norfolk CSB, Portsmouth Department of Behavioral Healthcare Services, Virginia Beach Department of MH/MR/SAS, and Western Tidewater CSB and Eastern State Hospital (ESH). Reinvestment partners identified by the Region include the involved CSBs, ESH, individuals, family members, advocates, private providers, police and sheriffs, judges, local governments, and the Department. The regional planning structure includes an HPR V Regional Partnership that consists of the nine CSB executive directors, the ESH facility director and the Department's Deputy Commissioner. The HPR V Regional Partnership established a Systems Oversight and Project Design Work Group comprised of CSB mental health and substance abuse directors; ESH clinical operations, acute care, medical, and nursing staff; individuals receiving services and family members; and Department consultants. Areas of work group emphasis include systems performance, clinical design, financial planning, and contract management.

The Eastern Regional Partnership solicited a wide range of local services system partner views regarding service capacity, service needs, priorities, and potential service realignments or restructuring opportunities through a Regional Stakeholder Forum at ESH in April 2003 and informational meetings with private providers, CSB psychiatrists, and various individual and family member advocacy groups. The region is planning regional and local activities to assure continuing input and involvement by services system partners, including public forums, focus groups, town meetings, surveys, and listening sessions.

In developing a cooperative plan for the HPR V Reinvestment Project, participants sought to uphold key clinical principles while enhancing community treatment services in ways that would more readily meet the needs of the region's citizens, achieve efficiencies in system wide administrative functions, and greatly improve the provision of services and oversight of service delivery structures. The region adopted the following principles: consumer-focus, continuum of care, flexibility and choice, community-based, reinvestment of resources, commitment to staff, maximization of funds, and financial viability. These principles are described at the beginning of Section VI in this Plan.

Over the past several years, the nine CSBs in HPR V and ESH have worked to improve efforts to divert persons deemed inappropriate for state hospital admission and to greatly solidify the gains made by hospitalized patients during their discharge process and the post-hospitalization period of transition back to community care. Several initiatives have targeted these efforts, including improvements in communication and the discharge process between hospital and CSB staff, alternative treatment remedies for persons suffering from primary substance use disorders, and pre- and post-inpatient treatment service alternatives aimed at community-based crisis intervention and increased retention of community tenure through addressing issues related to housing, medication, and basic health care.

To date, the Region has successfully implemented two state facility initiatives: a Discharge Assistance Project to assist in the preparation of individuals returning to the community after inpatient care and a Primary Substance Abuse Disorder Diversion Project aimed at finding alternatives to state facility hospitalization for individuals with acute symptoms related to substance abuse dependence.

The Eastern Region's Reinvestment Project builds on this work and furthers efforts to increase service flexibility, develop new and additional services within the community, increase individual

care oversight, and provide critical support to community structures recognized as basic to the emotional well being of individuals receiving services. Project goals are to:

- Provide better care;
- Serve more individuals;
- Increase CSB control over inpatient admissions and discharges;
- Reduce lengths of inpatient stays;
- Increase community service capacity; and
- Develop alternative methods to community care.

The Project will redistribute public dollars available to the area for the development of sub-acute service capacity within the community. Short-term, acute psychiatric stabilization would be provided exclusively by local inpatient hospitalization and community-based supports. This would effectively reserve ESH for the provision of psychiatric rehabilitation to individuals in need of longer-term hospitalization.

To implement a carefully phased relocation of acute care inpatient services from ESH to local providers, the Region will purchase and manage acute care in community hospitals, beginning with 43 of the 86 beds that now comprise the ESH Acute Care Unit. A Request for Proposals (RFP) for inpatient purchase of services has been issued and a Regional Authorization Committee has been established to screen individuals for hospital admission and perform utilization management activities. The Region is finalizing utilization management and performance outcome measures. The first ESH beds were closed on November 15, 2003. To reflect existing utilization, Region converted the remaining 43 beds to psychosocial rehabilitation use and will phase-out these beds in 2005.

Reinvestment dollars will provide added treatment services for individuals with co-occurring substance use disorders, increase the communication between community psychiatrists and inpatient hospital teams, and increase the use of services that stabilize persons within the communities in which they reside. In addition, CSBs are strengthening their crisis stabilization programs, training emergency services staff in the authorization process, training care coordinators in the reinvestment plan, and developing a care coordination plan.

In summary, this Project signals more than the redirection of service dollars; it affirms the belief that, where possible, healing is best done in one's own natural environment, in close proximity to one's friends and family, within one's home or neighborhood.

Far Southwestern Regional Partnership

Regional Partnership planning in far Southwestern Virginia is a natural extension of the usual activities of the Southwest Virginia Behavioral Health Board for Regional Planning (SWVBHB). Chartered in 1992, the SWVBHB consists of the Executive Directors of the region's six CSBs (Cumberland Mountain Community Services, Dickenson County Community Services, Highlands Community Services, Mount Rogers Community MH & MR Board, New River Valley Community Services, and Planning District One Behavioral Health Services), Southwestern Virginia Mental Health Institute (SWMHI) and Southwestern Virginia Training Center (SWVTVC) Directors, and individual and family representatives. Board members work closely with their clinical counterparts in the CSBs and state facilities, have an active role in leadership training for individuals receiving services, and support the development of family support groups in many communities.

In preparation for Reinvestment/Partnership Planning, the SWVBHB reviewed the Master Plan for Mental Health Services in Southwestern Virginia, developed in 1995, and updated its Guiding Principles. The Master Plan and these Guiding Principles, along with the Department's Guiding Principles for Restructuring, are providing the values and vision for the region's processes. The SWVBHB Guiding Principles follow.

Guiding Principles for Behavioral Health Service Delivery for the SWVBHB
February 2003

- Persons shall have the ***opportunity to lead productive lives*** and make significant contributions to the communities in which they live.
- Treatment and support services shall be provided in such a way as to ***minimize disruptions*** in community living.
- Responsive behavioral health services retain ***responsibility for serving all persons*** with mental illness, mental retardation, and/or substance abuse disorders regardless of severity of needs or current residential situation.
- The effective delivery of behavioral health services requires a ***comprehensive, coordinated array of services with 24 hour access to necessary treatment***.
- Effective service systems for persons with behavioral health problems ***prioritize and utilize resources for those most in need***.
- The most effective use of system resources is to focus on ***natural supports, state-of-the-art clinical and services approaches, and new technologies*** for service delivery.
- The development and provision of services shall be ***guided by the needs and desires of consumers***, with consideration for families and the community.
- Persons have the ***right to be actively involved in and make meaningful choices about their treatment and the services they use***; this process shall be one characterized by ***respect and dignity***.
- Decisions about where, with whom, and how to live, work, and socialize are inherently personal and differ for each individual. People with mental illness, mental retardation, and/or substance abuse disorders have the ***right to the same range of options available to the general public***, including selecting their residences, work options, social/recreational/educational activities, and medical care.
- Mechanisms shall be available to ***ensure individuals'*** rights.
- Services shall be highly ***individualized and flexible***, recognizing the unique needs, desires, hopes and strengths of each person
- All services should be ***relevant and responsive to the culture, ethnicity, age, gender and sexual orientation of the persons served***, and staff should be given adequate training, and demonstrate competence, in providing such relevant services.
- ***Taking control over and responsibility for one's own life and behavior*** is an essential factor in coping with and recovering from mental illness and other behavioral health problems.
- A person's ***natural support system***, including family, significant others, peers, self-help groups, and other community groups and organizations are essential to recovery and community integration.
- ***Family members have a unique, integral role***, and their needs and perspectives shall be included in the development and implementation of services.
- ***Consumers and family members shall have opportunities for adequate education, training and supports*** to effectively participate in system activities.
- Effective service systems ***value and empower staff***, and provide supports to ensure that they have adequate training and professional and personal resources to perform their jobs competently, and with compassion, understanding and respect.
- The system of supports and services shall promote ***partnerships among consumers, families and staff***
- The development of effective service systems requires ***strong leadership***. The purpose of behavioral health services cannot be accomplished without clearly defined expectations, responsibilities, authority and accountability.
- All behavioral health services shall ***promote recovery and community integration and instill hope*** for the future.

The Family and Consumer Support Services Committee of the SWVBHB obtained broad input from its partners through regional Partnership Planning meetings. The first "specialized stakeholder" meeting was held on July 25, 2003 in Wytheville. Five additional Partnership Planning meetings were held in September around the region. The region's active family support groups were major participants in these public forums. Other interested advocates and other services system partners in the Far Southwestern Virginia Region, such as private

inpatient providers, assisted living facility and nursing home operators, social services departments, and sheriffs/judicial systems will be invited and encouraged to become involved. This participation will help guide the development of plans to improve regional and local systems of care and set priorities for the Region's efforts.

The Transition to Reinvestment Workgroup (TRW), a working subgroup of the SWVBHB for Regional Planning, has been meeting almost every other week throughout the spring and summer of 2003. It consists of the CSB Mental Health Directors for the region, the SWVMHI Director, Central Office staff, and individual and family representatives. Key activities include:

- Identification of "best practices" (clinical or revenue enhancing) that could be shared and adopted by the Region without new resources;
- Identification of infrastructure needs of the Region, particularly the core components of services that are needed by individuals;
- Identification and collection of a variety of outcome measures, so that success can be measured in a variety of domains;
- Development of consensus around bed purchase and utilization review activities; and
- Additional meetings with legislators and other specialized groups such as private inpatient psychiatric providers.

The TRW is collecting data that will help address "best practices" and regional infrastructure needs and will present results to the SWVBHB for its endorsement. The findings will then be forwarded to the Department. A Project Manager began his duties on September 2, 2003. His first priorities are to summarize results for the Regional Partnership Planning partners meetings and develop a proposal and data elements for the regional adult inpatient Utilization Management program.

The region does not want to just swap "beds for beds," i.e. buy private beds as a replacement for state hospital beds without an assurance that the quality of care will be at least the same if not better than state hospital care. Solely focusing on bed purchases will not fully address the long-term care issues that the Region faces. Rather, the Region believes that new transitional and alternative housing services are essential to reduce the need for state hospital admissions and shorten state hospital lengths of stay. Other community supports and services also should be developed and enhanced. These include crisis intervention services, case management, jail, and psychiatric services. Another area of interest to the Region is the development of additional services for individuals with dual diagnoses and those who are considered difficult to manage. The Region is likely to propose that two years' worth of "bridge funding" is necessary to ensure that there are funds and time enough for infrastructure development.

The SWVBHB has recommended the following state-level actions for consideration by the Department:

- Conduct a statewide study to review continuity of care procedures that are to be followed when discharging a person from an inpatient facility to a different service area to address instances where referrals are not always made to the receiving CSB and to consider re-admissions back to the sending facility when needed within a certain number of days of discharge, particularly when family is involved.
- Address the need for mental health and forensic evaluation services in jails, as these persons are frequently services system individuals who are only "housed" in a non-Department setting.
- Address the lack of board-certified psychiatrists, including child and adolescent psychiatrists, who are willing to work for CSBs.

Northern Regional Partnership

In December 2002, the Northern Virginia Regional Partnership Planning Project began, co-chaired by the Executive Director of the Fairfax-Falls Church CSB and the Director of the Northern Virginia Mental Health Institute (NVMHI). A broad representation of regional partners, including Board chairs and staff from the five Northern Virginia CSBs (Alexandria CSB, Arlington CSB, Fairfax-Falls Church CSB, Loudoun County CSB, and Prince William County CSB), Directors and staff of two state facilities [NVMHI and Northern Virginia Training Center (NVTC)], the Health Systems Agency of Northern Virginia, advocates from each of the service areas, services recipients, and providers from the private sector, is participating in this planning project.

The Steering Committee for the Northern Virginia Planning Project determined that it would focus on adult mental health services with a special emphasis on persons with serious mental illness. Several work groups were established to address specific issues intensively. The Mental Health Work Group (MHWG) is addressing hospitalization utilization, forensics and NGRI (Not Guilty by Reason of Insanity) status, co-occurring mental illness/substance abuse disorders, and other related issues. The Structural Work Group (SWG) is reviewing the overall structure that supports mental health services in Northern Virginia. A Private Hospital Work Group (PHWG) is discussing issues common to both public and private psychiatric hospital services. Two existing groups also contributed to the process: one elaborated on issues facing older adults with mental illness or with dementia, and the other addressed co-occurring mental retardation and mental illness issues.

One of the first tasks facing the Steering Committee was to develop a vision statement and guiding principles, emphasizing the use of the Recovery Model in service planning and practice. Once completed, the statement and principles were used to guide the planning process. The vision for mental health services focused on development of a cost-effective, comprehensive, culturally competent array of recovery-oriented, consumer choice-driven, integrated services that are flexible and accessible to individuals and oriented toward proactive care, maintaining stability and maximizing independence and community integration. Education must be intensified to combat and overcome discrimination historically associated with mental illness. Guiding principles and objectives for the Regional Partnership follow.

<u>Ensure Quality Services</u>

- ❍ Education should be available on how to access services.
- ❍ Individuals receiving services and caregivers should be educated about how to get the most benefit from the services they receive.
- ❍ Sufficient capacity should exist throughout the system.
- ❍ Treatment and services should be available for Northern Virginians within the region.
- ❍ Outcomes should focus on recovery, quality of life, sufficiency and well being.
- ❍ A proactive model that avoids crises, both for individuals receiving services and for providers, should be achieved.
- ❍ Services should be based on best practice models and evidence-based research.
- ❍ Services should be culturally competent.
- ❍ Services should address the co-occurrence of behavioral and medical problems.
- ❍ Services should be guided by the principles of the Recovery Model, and education should be provided for self-management, self-advocacy and achieving wellness.

<u>Ensure Protections for Individual's Receiving Services and Families Are in Place</u>

- ❍ Fully educate individuals regarding their rights, assure compliance with human rights regulations and protect individuals against discrimination.
- ❍ Fully involve individuals, family members and caregivers in system-wide planning activities and program evaluations and provide them with adequate support when needed.

- Provide support appropriate to those exercising their rights under the Human Rights Regulations or other disability protections.
- Individuals receiving services and their families or guardians should be encouraged to communicate their concerns and interests to caregivers in order to fully participate in planning the system of services.
- Individuals, families, and caregivers should fully participate in developing treatment plans. They should be able to exercise preference and choice in treatment services.
- Services at all points in the continuum will support self-management and minimize coercive measures; safety of individuals receiving services and staff is paramount.
- Encourage individuals, families, and caregivers to seek out educational resources.

Broaden Community Service Options

- Service options for persons with co-occurring mental illness and substance use disorders and for co-occurring mental retardation and mental illness disorders should be provided through an integrated system.
- The continuum of services should include full range of needed services, including acute hospital care and other medical services.
- Service options should emphasize community integration, utilize natural support systems, be easily accessible, and include an array of employment and housing options.
- Service options should also include age appropriate services for youth transitioning to adult services and for older adults.
- Service options should include peer support and services operated by services recipients.

Address Work Force Issues

- Strengthen recruitment and retention activities across the entire system including state facilities, CSBs and private providers.
- Develop mechanisms that facilitate the ability of staff to transfer to different employers within the system.
- Encourage training and employment of individuals receiving services as providers.

Maximize Revenue, Minimize Cost

- Fully utilize private and non-profit service providers to expand capacity and increase choices.
- Use cost benefit analysis whenever appropriate in planning system change.
- Balance accessibility and cost in Regional Program Planning.
- Pursue simplification of funding streams and elimination of unnecessary barriers to eligibility.
- Maximize Medicaid funding by enrolling individuals in Medicaid, encouraging providers to become Medicaid vendors, and matching individuals to providers of Medicaid services.

The MHWG, a large group comprised of representatives from the CSBs and state facilities, private providers, individuals receiving services, and advocates, meets monthly and sometimes more frequently to openly discuss issues, evaluate data pertaining to specific mental health issues, and suggest ways in which services may be improved. Early on, the MHWG adopted the Recovery Model as the philosophical underpinning for its reviews and recommendations. The Recovery Model is based on the following premises.

- A holistic view of mental illness focuses on the person, not just the symptoms.
- Recovery is not a function of one's theory about the causes of mental illness.
- Recovery from severe psychiatric disabilities is achievable.
- Recovery can occur even though symptoms may reoccur.
    - Individuals are responsible for the solution, not the problem.

- Recovery requires a well-organized support system that incorporates rights of individuals receiving services, advocacy, social change, and applications and adaptations to issues of human diversity.

The MHWG identified the need for a descriptive model that could be used to illustrate the different service needs of individuals requiring psychiatric inpatient care. NVMHI participants developed a model describing four levels of inpatient treatment that was subsequently adopted by the MHWG. Levels in this model are: Level I Acute Stabilization (Admission), Level II Intensive Care (Admission), Level III Intermediate Care, and Level IV Rehabilitation Services. This multi-variant model categorizes patients' treatment levels according to acuity, complexity, and expected length of stay. It includes a patient profile, specific interventions, and expected outcomes for each level. This model was applied to patient populations at NVMHI, WSH, and Northern Virginia private hospitals in order to determine the percentage of patients receiving each level of treatment at each facility. The resulting findings are summarized below.

- Public sector hospitals presently provide care mainly for individuals who need intermediate care or rehabilitative services, whose acuity is low or variable, whose complexity is high, and who need more than 30 days of inpatient service.
- Private sector hospitals care primarily for individuals who need acute stabilization or intensive care, whose acuity is high, with low or high complexity, and who need less than 30 days of inpatient service.
- Private sector hospitals are challenged to manage certain individuals in Level II Intensive Care and some of these individuals are refused admission to these settings even if they have insurance.
- While NVMHI has the expertise to provide Level II Intensive Care, its ability to do so is limited because of the number of hospitalized individuals who could be served in the community if community capacity were expanded.
- People with any illness requiring ongoing medication sometimes stop or refuse their medications. Private hospitals are particularly challenged to provide psychiatric treatment to persons who refuse medication since these hospitals currently do not seek or arrange for legally authorized representatives.
- Some private hospitals have been developing special capabilities within their psychiatric units. Inova Mount Vernon, for example, has a more comprehensive service and is not focused on just acute or intensive care, and Loudoun Hospital Center has a strong geriatric psychiatric center

The Northern Virginia region currently has an excellent array of private providers of mental health services. In March 2003, the PHWG was formed, consisting of representatives from eight private sector hospitals with a psychiatric unit, one freestanding psychiatric hospital in Northern Virginia, the CSBs, MHWG, and advocacy organizations. This group meets monthly and also completed special assignments between meetings. In order to further enhance collaboration with the provider community, a dialogue among public and private sector inpatient hospital providers has been initiated.

To address problems associated with serving older adults with mental illness and persons with dementia who have psychiatric symptoms, an existing regional work group recommended the following actions.

- An independent group should do a study, focusing on these four issues:
  - Psychiatric hospitalization, both public and private;
  - Institutional placement, including nursing homes and assisted living facilities;
  - Age-appropriate availability of the full range of services offered by community mental health centers, including psychosocial day programming, and housing; and
  - Private community resources.

- The criteria for individuals with Serious Mental Illness and Priority Populations should be re-written to be more inclusive of older adults and adults who have behavioral and psychiatric symptoms related to dementia and related illnesses.
- A pilot program should be initiated to develop a coordinated approach for a continuum of care among the following groups: one or two nursing homes, one or two assisted living facilities, a community mental health geriatric program, a community mental health emergency service, a local medical hospital psychiatric unit, and a state geriatric psychiatric unit.

These recommendations, as well as other possible approaches, will be studied further by the Steering Committee.

To address issues associated with serving individuals with co-occurring mental retardation and mental illness (MR/MI), the Northern Virginia Regional Dual Diagnosis (MR/MI) Workgroup, which includes individuals, families, advocates, the five Northern Virginia CSBs, private residential providers, vocational day placement providers, community behavioral consultants, NVTC, NVMHI, and George Mason University, found that while some individuals with MR/MI issues are served well, there is a general agreement and understanding that individuals with MR/MI are often underserved. Relatively few individuals with dual diagnosis need institutional care; but when it is needed, it should be easily obtained with the minimum of bureaucracy. The greatest need is for community-based mental health services that provide in-home supports, partial hospitalization and crisis stabilization. Interdisciplinary assessment and training is needed for staff of mental retardation and mental health agencies. The Steering Committee accepted the report and will explore its recommendations.

The Structural Work Group (SWG) was tasked by the Steering Committee with identifying regional issues and recommending regional solutions. Members of the SWG include the chairs and Executive Directors of the five Northern Virginia CSBs, the Directors of NVMHI and NVTC, and representatives of individuals receiving services. Among the issues being addressed by the SWG are: information technology, training, quality assurance and quality improvement, reimbursement activities, center for excellence, cultural competence, evidence-based practices, services for deaf and other specialized populations, prevention, regional approaches to grants, collaboration with various community organizations, emergency response and management, Medicaid revenue maximization, and coordination of regional mental health issues.

Following discussion of employment needs of persons with serious mental illness, the Steering Committee endorsed a federal WorkFORCE grant application submitted by vaACCSES in collaboration with several state and regional agencies.

In Northern Virginia, the number of persons with no health insurance or inadequate coverage for psychiatric care is increasing. Many indigent people are ineligible for Medicaid because of Virginia's restrictive eligibility criteria. Most of the 28 percent of persons who are uninsured are treated as charity care by private hospitals. While the regional partners continue to explore all options, in light of the growing demand and the uncertainty regarding the future capacity and location of private sector psychiatric beds, it is unlikely that beds can be closed at NVMHI and corresponding funds moved to the community. As a result of this planning process, the Steering Committee developed a plan to transfer about $2.5 million in state funds from NVMHI to the five CSBs. The process improved coordination and communication among public and private providers. Next steps to implement this plan are listed below.

- All CSBs and NVMHI will sign the interim agreement for the period July 1, 2003 through October 31, 2003.
- The Discharge Assistance and Diversion (DAD) Steering and Coordinating Committees will develop proposals for the use of any unencumbered funds for FY 2004.
- Funding for the existing DAD Aftercare projects will be transferred to individual CSBs as soon as feasible.

- The Steering Committee of the Northern Virginia Regional Partnership Planning Project and the CSBs will be asked to endorse the concept.
- The Fairfax-Falls Church CSB will develop the necessary administrative procedures so that it can temporarily serve as the fiscal agent.
- Planning will begin immediately on developing a revised DAD agreement effective November 1, 2003 to transfer the fiscal agent responsibilities to a CSB on a permanent basis.

This transfer of funds and the fiscal agent responsibilities to a CSB is consistent with the Governor's Reinvestment Initiative. The transfer will maintain the current collaborative structure of the DAD project, which includes all of the CSBs, NVMHI, and the Department. It will provide even greater flexibility in how the funds can be used without shifting any additional responsibility for providing inpatient services to CSBs. Project funds will also be used to cover related administrative services.

Led by the Structural Work Group, the Steering Committee and its other work groups identified statewide policies issues that include three recommendations for State-level actions.

- Address several forensic/NGRI issues
  - Advocate that SSDI be available again to forensic patients in state facilities;
  - Increase the funding for follow along services that facilitate community integration and transition;
  - Support expedited community integration;
  - Study the reasons for differential rates of adjudication, lengths of stay, and progress through the privileging system; and
  - Initiate policy or statutory changes that would allow people on NGRI status to be housed in a step-down program in the community prior to conditional release.
- Provide support for ongoing empowerment training for individuals, similar to the Consumer Education and Leadership Training (CELT) offered by the Mental Health Association of Virginia, and wellness training. Encourage this training to be offered in Northern Virginia.
- Implement a Consumer and Family Affairs Office in the Department's Central Office.

In preparation for the continuation of this process, the work groups identified the following issues to be considered in the next planning phase.

Service Issues

- Recovery Model
- Movement of patients from institutions to community re: the Olmstead decision
- Greater emphasis on employment services
- Services appropriate to settings, e.g., nursing home, jails, and shelters
- PACT teams
- Availability of medications across the region
- Pharmacies
- Psychiatrists and nurses for medication clinics
- Resource gaps, especially residential, day programming, and possibly in-home services

Service Populations

- Youth and families
- Persons with co-occurring mental illness and substance abuse
- Persons with co-occurring mental retardation and mental illness

Forensics

- Use of earmarked funds for NGRI

- Community education re: use of Western State Hospital Forensics Unit
- Forensics population data

Hospital Issues

- Use of private psychiatric hospital beds
- Differential utilization of Private Bed Purchase (PBP) by CSBs
- Random nature of monthly demand for PBP

Funding Issues

- Reinvestment funds
  - Diversion strategies and services
  - Discharge strategies and services
- Incentives and disincentives
- Per capita expenditures
- WorkFORCE Action Grant Initiative

Service Recipient Issues

- Consumer Empowerment and Leadership Training (Mental Health Association of Virginia)
- Family education
- Consumer-directed services.

The Steering Committee has concluded that no beds should be closed at NVMHI at this time. This recommendation is based on anticipated population growth through 2010 and the proposed reduction in private sector psychiatric beds for adults in Northern Virginia.

Initial Recommendations:

- Improve Virginia's Medical Assistance Plan by increasing the eligibility level from 80 percent to 100 percent of the federal poverty level, setting rates at a level sufficient to cover the costs of all Medicaid services, and expanding the array of services (e.g., PACT as a bundled service).
- Provide adequate funding, which is desperately needed, for the entire continuum of community-based services.
- Foster greater use of private sector providers by ensuring that they are reimbursed adequately by all sources, including public payers such as Medicaid and the Department and private insurance companies, for inpatient psychiatric care;
- Maintain the current bed capacity of NVMHI in light of increasing population and proposed reductions in the number of beds in the private sector.
- Support implementation of a Regional Reinvestment Initiative to transfer about $2.5 million in State funds for NVMHI to CSBs, with these funds used primarily to purchase short-term inpatient psychiatric care in the private sector;
- Actively promote the Recovery Model throughout the Commonwealth;
- Establish an Office of Consumer and Family Affairs in the Department's Central Office;
- Establish and fund empowerment training for individuals throughout the Commonwealth;
- Make an array of community-based services such as locked residential programs more readily available for persons in state facilities in NGRI status;
- Request that the State design, in collaboration with the private sector, a system for properly addressing the growing need for services for older adults with mental illness and persons with dementia who have psychiatric symptoms; and
- Request that the Department carefully consider the recommendations from the regional work groups studying how to better serve persons with a dual diagnosis of mental illness and mental retardation.

Northwestern Regional Partnership

The Northwestern Region covers Central Virginia Community Services, Harrisonburg-Rockingham CSB, Northwestern Community Services, Rappahannock Area CSB, Rappahannock-Rapidan CSB, Region Ten CSB, Rockbridge Area CSB, Valley CSB, and Western State Hospital (WSH). The vision of the Regional Partnership is to provide flexible, nondiscriminatory, comprehensive, outcome-driven services to all population groups; to honor individual and family caregiver collaboration at all levels; and to ensure streamlined access to services and funding.

The following regional strategies would improve regional and local systems of care and provide the level of care needed by individuals receiving or requiring services and their families.

Adult Mental Health:

- Establish two crisis stabilization programs within the region serving the entire region under regional management,
- Establish PACT Teams within each CSB,
- Enhance clubhouse programming to include activities and vocational assistance. Establish a minimum of four vocational provider positions within each clubhouse, and
- Establish an ICF/MR modeled after the SWVTC program for individuals with dual diagnoses on the campus of CVTC for qualified individuals with behavior problems.

Adult Substance Abuse:

- Make much-needed improvements to the Boxwood facility, and
- Seek Medicaid reimbursement for substance abuse services.

Adolescent Services:

- Develop a regional ICF/MR for children and adolescents,
- Develop regional crisis stabilization services,
- Enhance and expand transition services for children with MR going into and coming out of schools,
- Develop regional adolescent detoxification and treatment services, and
- Fund a discharge project for children and youth with discharge needs when leaving the Commonwealth Center for Children and Adolescents.

General:

- Make Medicaid eligibility available to a wider variety of individuals and increase the poverty level percentage,
- Fully reinstate CSB funding cuts to provide accessibility to all services for non-Medicaid service recipients,
- Develop specialized housing and necessary supports, and
- Develop services for individuals with autism.

The following state and regional funding concerns were identified during the Regional Partnership Planning meetings.

- Fully return CSBs and WSH to previous level of funding. Being able to adequately fund services to all individuals, but particularly to those who are not Medicaid eligible, is a top priority for the region. CSBs and WSH will collaborate to deploy restored funding.
- Provide funding for acute care bed purchase for short-term stabilization and diversion of admissions from WSH.
- Achieve better utilization of Medicaid dollars and fund more MR waiver slots.

- Implement a regional carve-out for the proceeds from the DAP funds which would reallocate DAP funds through a Regional Partnership process.
- Provide bridge funding for the development of an ICF/MR on the CVTC or WSH campus.
- Increase funding for children's services thorough a dedicated, flexible funding stream.
- Provide adequate state funding for services to non-mandated children and youth under the Comprehensive Services Act.

The Regional Partnership identified the following issues related to adult and child mental health community infrastructure that require state-level action.

- Medicare, Medicaid, and third party payers provide different reimbursement rates and rates that vary from year-to-year. For instance, the recent decrease in Medicaid reimbursement provides a funding level that is significantly less than the daily private hospital costs. This change stresses both the private and public systems.
- Overall shortage of psychiatric beds, some of which is related to the previous issue: It is difficult to fund beds when reimbursement does not come close to covering the costs of services.
- The development of more cost-effective treatment options for children with dual diagnoses and serious behavior problems who are presently being placed out-of-state due to lack of resources in the state;
- Lack of availability of Medicaid waiver funding for mental health services.
- Need for more consumer-driven services and increased capacity in existing systems.
- Lack of full funding for community services rather than state facility-based services.
- Lack of a statewide coordinated system of care and funding for children's services.

The Regional Partnership recommends that the state move to address these issues in order to insure that Virginia's individuals receiving mental health services receive an appropriate level and continuum of care. The Regional Partnership further recommends that the Department establish an integrated organizational structure for child, adolescent, and family services, and that this unit report directly to the Assistant Commissioner of Community Services. This unit could also provide training and technical assistance in systems of care that provide multi-agency coordinated services for children and families.

Southern Regional Partnership

The Southern Region covers Danville-Pittsylvania Community Services, Piedmont Community Services, Southside CSB, and Southern Virginia Mental Health Institute (SVMHI). The mission of the Southside Behavioral Health Consortium is to establish, maintain, and promote a regional system of care in the areas of mental health, mental retardation, and substance abuse that is community-based. Guiding principles follow.

- The needs of individuals receiving services will be the foundation of the planning process.
- Involvement of key regional partners, including representatives of regional organizations for individuals receiving services and their family members, advocacy organizations, public and private service providers, state and local public officials, and other interested individuals from the region served by the Consortium will be sought and encouraged.
- The Consortium will develop strategies, programmatic structures, and services to improve regional and local systems of service delivery, where severity of an individual's disability determines the most appropriate location, level, type, and intensity of care.
- The Consortium is committed to the retention, redeployment as necessary, training, and development of public services system staff.
- The Consortium will make the most efficient and effective use of all available public funds and resources.

The Consortium, whose leadership consists of the Executive Directors of the three CSBs and SVMHI, facilitates a strategic, long-term process to achieve a truly community-based system of care. This process includes ongoing comprehensive assessment of the needs of individuals receiving services, assessment of programmatic changes required to meet those needs, and implementation of interventions and care appropriate to individuals' needs in the region.

The Consortium solicited input from community services system partners in the development of its plan. Two forums were held in Danville and four sub-regional forums in Danville, Martinsville, Rocky Mount, and South Boston. Participants in these forums included individuals receiving services; parents and family members; private services providers, including community hospitals; local chapters of the National Alliance for the Mentally Ill and the Mental Health Association; community recreation centers; commonwealth attorneys; judges; sheriffs; juvenile/domestic relations courts; city and county governments; schools; local health and social service departments; CSB and state facility staff; United Way Chapters; and Comprehensive Services Act (CSA) representatives.

The Consortium's regional plan focuses on supporting and maintaining existing core services operated by the respective CSBs and the inpatient psychiatric care provided by SVMHI. Its immediate goal is to expand the region's community services capacity to maximize the ability of individuals to access services that are essential for them to remain in their respective communities. Development of community infrastructure, both public and private, is essential to the accomplishment of this goal. The Regional Consortium proposes additional state funding to support community capacity expansion and enhance collaboration between the CSBs and SVMHI. This funding would support specific community mental health, mental retardation, and substance abuse service capacity expansions identified in the tables below. If funded, these proposed service capacity expansions would provide necessary alternatives that would significantly reduce demand for state facility services.

Proposed Mental Health Service Expansions

Priority 1	Priority 2	Priority 3
Intermediate Care/Crisis Intervention for Adults, Including Residential Supports, Crisis Stabilization, Intensive Residential Crisis Intervention, Respite Housing, and Diversion to Private Hospitals	Program of Assertive Community Treatment (PACT) (One for Each CSB)	Dual Diagnosis Specialized Services (2 FTE to Coordinate Admissions, Discharge Planning, and Treatment Programming for SVMHI, One for MI/SA and One for MI/MR and to Consult with the 3 CSBs)
Child Psychiatry (1 FTE to serve the 3 CSBs)	Wrap-around Services for Children and Adolescents, Including Behavioral Specialist Services, Counseling, In-Home Stabilization, Respite Care, Long-Term In-Home Services, and MI/MR Services	Intensive Day Treatment for Children and Adolescents (Two Regional Programs)

Proposed Mental Retardation Service Expansions

Priority 1	Priority 2	Priority 3
Residential Services for Adults (One 8 Bed Community ICF/MR facility in each of the CSBs)	Consultation Services for Adults and Children and Adolescents	Community Transition (Start-up and Waiver Funding for 32 CVTC Residents to Move to Community Placements)

Priority 1	Priority 2	Priority 3
Skilled Nursing for Children and Adolescents (One Skilled Nursing Facility for Medically Fragile Children with Mental Retardation in the Region)	+++++++++	Crisis Stabilization for Adults (Utilize 2 Beds at CVTC and 1 Bed at SVTC for Crisis Stabilization as an Alternative to Emergency Admissions to SVMHI)
+++++++++	+++++++++	Consultation and Training/Education for Children/Adolescent Services (Regional Team Focused on MI/MR)

Proposed Substance Abuse Service Expansions

Priority 1	Priority 2	Priority 3
Shared CSB Crisis Stabilization (24-Hour Site), Psychiatric Services (1 FTE Psychiatrist with a Specialty in Addictions), Intensive Case Management, and Intensive Outpatient Services for Adults	Wrap-around Services for Adults [Funding Would Be Shared by the 3 CSBs, as Needed for Program Development and Expansion; Coordination Among the CSBs; and Consumer Assistance to Obtain Supplemental Security Income, DSS Entitlement Programs, Housing, Employment Assistance, Peer Education/Support, Health Services (HIV, TB, Sexually Transmitted Diseases), and Post-Incarceration Supports]	Regional Specialized Services for Individuals with Barriers to Treatment (Individuals Who Have MI/SA, Who Have MIR/SA, Who Are Ex-Offenders, Who Have Hearing/Sight Impairments, Those Whose First Language Learned Is Not English, and Who Have Brain Injuries/Organic Disorders)
Outpatient Services (Particularly for Those with Dual Diagnoses) and Inpatient/Residential Treatment (Purchase of Services at Private Treatment Facilities) for Children and Adolescents		

Regional partners identified a number of issues for further consideration by the Regional Consortium, including:

- Developing a system of tracking available public and private beds through the Internet for use by CSB prescreeners and hospitals;
- Advocating for increased Medicaid rates and additional MR waiver slots;
- Seeking funding for a variety of individual needs, including:
  - Additional social and recreational services for children and youth,
  - Medical and dental services for indigent individuals,
  - MH employment service supplements,
  - Public guardianship programs,
  - Expanded services for Part C-eligible individuals,
  - MR services for individuals who are not eligible for the Medicaid MR Waiver, and
  - Intensive SA services upon demand;
- Providing technical or practical assistance in physician recruitment, particularly psychiatrists;
- Minimizing the use of physical restraints on individuals being transported by law enforcement personnel;
- Dispensing medications through private pharmacies instead of mental health clinics;
- Providing access to intensive SA services when individuals are in a withdrawal state, in the midst of a life crisis, or struggling to develop a lifestyle that maintains abstinence;
- Addressing relapse and recidivism issues among individuals receiving SA services; and

- Continuing to address the increasing numbers of individuals receiving SA services who have special service needs.

Activities of the Special Population Work Groups

On June 24, 2003, the Department convened the Restructuring Policy Advisory Committee (RPAC) to provide advice on statewide policy issues associated with services system restructuring. RPAC membership includes representatives from statewide individual and family advocacy organizations, private provider organizations, CSBs, state facilities, local government associations, universities, health care practitioners, the Inspector General, state agencies, the State Board, and the Department's Central Office.

The RPAC is overseeing the efforts of five Special Population Work Groups. Because the three Reinvestment Initiatives are focusing primarily on adult mental health services, the Department established Work Groups to examine service needs, challenges, and barriers in addressing the needs of child and adolescent, gero-psychiatric, forensic, mental retardation, and substance abuse populations. These Work Groups will meet over the next year to develop strategic plans that identify and address services needs and challenges, potential incentives, and collaborative opportunities. Summaries of the work and recommendations of these Work Groups follow.

Child and Adolescent Population Work Group

Mental Health: A Report of the Surgeon General Surgeon cites concerns about inappropriate diagnoses of children's mental health problems. Too often, children with mental health problems do not receive services until they end up in a secure setting such as a hospital, detention center, jail, or a state juvenile correctional facility. The Report identified the following mental disorders with their onset in childhood and adolescence: anxiety disorders, learning and communication disorders, attention-deficit and disruptive behavior disorders, mood disorders (e.g. depressive disorders), autism and other pervasive developmental disorders, eating disorders, tic disorders, and elimination disorders.

According to the *Surgeon General's Report*, both biological factors and adverse psychosocial experiences during childhood influence but do not necessarily "cause" mental disorders in children. Their effect depends on individual differences among children, the children's ages, and whether these factors or experiences occur alone or in combination with other risk factors. The *Report* cites the following risk factors for developing mental disorders or experiencing social-emotional problems:

- Prenatal damage from exposure to alcohol, illegal drugs, or tobacco;
- Low birth weight;
- Difficult temperament or and inherited predisposition to a mental disorder;
- External risk factors such as poverty, deprivation, abuse, or neglect;
- Unsatisfactory relationships;
- Parental mental disorders; and
- Exposure to traumatic events. (*Surgeon General's Report*, p. 129)

A growing body of empirical evidence estimates a prevalence rate as high as 50 percent for the co-occurrence of alcohol and other drug use among adolescents with mental health disorders. Recent studies suggest that these adolescents have special treatment needs, including:

- Attention to developmental and other characteristics of adolescents,
- A treatment focus that examines and involves the adolescent's social and familial networks,
- The adaptation of clinical interventions for adolescents with dual diagnoses, and
- The need for services to be coordinated and integrated across multiple systems and points of contact. (Petrila, Foster-Johnson and Greenbaum, 1996)

Coordinating mental health and substance abuse systems of care would address the complex needs of adolescents with both problems. Service needs for adolescents coping with co-occurring disorders include crisis intervention, inpatient programs, residential treatment programs, day treatment programs, and outpatient counseling. (Fleich, 1991) The Department has typically addressed the needs of children according to the specific disability area in which the child entered services. Nationally, as well as in Virginia, increasing emphasis is being given to integrating treatment services and supports for this population. Regardless of how their needs are identified in a system of care, children and adolescents should have access to mental health and substance abuse prevention services, adequate assessments, evaluation and diagnosis, and appropriate treatment, when needed.

The 2000-2002 Appropriation Act included language (Item 329-G) directing the Department and the Department of Medical Assistance Services, in cooperation with the Office of Comprehensive Services, CSBs, and court service units, to develop an integrated policy and plan, including the necessary legislation and budget amendments, to provide and improve access by children to mental health and mental retardation services. The goal of this integrated policy and plan is to provide improved access for children and adolescents and their families to needed mental health, mental retardation, and substance abuse services. The Department established a workgroup representing CSBs, state agencies, parents, and other partners to identify service needs and develop the *Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Services for Children, Adolescents and Their Families*, hereafter referred as the 329-G Report. General recommendations included:

- Integrate services across disciplines and agencies.
- Implement statewide training on child mental health issues.
- Develop new services and address gaps in existing services.
- Increase the number of board certified/eligible child psychiatrists and trained clinical psychologists.

The Child and Adolescent Special Population Work Group met for the first time on August 8, 2003. Twenty-one representatives from parent organizations, CSBs, state and private hospitals serving children, and state agencies met to make recommendations to enhance community and facility services to support children and adolescents and their families. The Work Group discussed and supported the *Collection of Evidence-Based Treatment Modalities for Children and Adolescents with Mental Health Treatment Needs*, compiled by the Virginia Commission on Youth, and the 329-G Report. The Work Group also reviewed the issues identified at the June 24th meeting of the Restructuring Policy Advisory Committee. Five broad themes were identified: best practices; capacity building; service integration; needs of special populations; and hospital, residential, and detention center facility needs. Five small groups were formed around these themes to make short-term budget recommendations. Work Group recommendations for 2004-2006 biennium budget funding follow.

1. Statewide CSB cross-consultation and training ($200,000 jointly managed by the Department and VACSB.
2. Dedicated funding for child and adolescent MH, MR, SA, and early intervention services. ($40 million divided across the CSBs).
3. Medicaid rate increase for MH Clinics, EPSDT (day and intensive in-home) and psychiatric acute inpatient services (10 percent annually) and increase the diagnoses covered to include all Axis I diagnoses (except nicotine dependence.
4. Child board-eligible or certified psychiatrists at each CSB ($8 million)
5. CCCA and SWVMHI stipends for child psychiatry fellows and doctoral interns in clinical psychology to build Virginia capacity ($290,000).
6. Grant support for matching funds for five consecutive years ($1 million).

Work Group recommendations not linked to funding follow.

1. Develop and promote a vision and roadmap for the integration of child and family services statewide and do strategic planning.
2. Disseminate the Commission on Youth's "Collection" of evidence-based practices.
3. Seek grant funding options (through private foundations) to build matching funds capacity.
4. Support the development of a statewide bed tracking system.
5. Dialogue with state universities on capacity building, especially child psychiatrists and psychologists.
6. Review and revise the Department's discharge protocols for children and adolescents.

The work group will continue to develop plans related to:

Community-based best practices

1. Further dissemination of the Commission on Youth's evidence-based document
2. Long-term university partnerships for training, research, and evaluation
3. Peer to peer training and consultation to build programs
4. Integrated case management
5. Opportunities for grant funding, including building matching funds capacity
6. Advocacy/support groups
7. University partnerships to build capacity for community fellowships and board certification.

Integration of services and addressing the needs of special populations

1. Study the feasibility of statewide department to oversee all children's services
2. Identify special populations within the child and adolescent population (e.g., MR, autism/DD and sex offenders) and develop models for treatment to include:
    a. Mobile crisis team/crisis stabilization—including psychiatry and psychology as disciplines represented (board certified or board eligible psychiatrists)
    b. Early intervention
    c. Prevention
    d. Transition services (16 or older)
    e. Family support services

Residential and Detention Services

1. Dual diagnoses (MR/MH and SA/MH) residential beds
2. ICF/MR for youth
3. MH services in detention.

Gero-Psychiatric Population Work Group

Nationally, older adults (aged 65 years and older) account for about 12.4 percent of the total population. The anticipated impact of aging "baby boomers" will increase this proportion to 20 percent by 2030. (Federal Interagency Forum on Aging, in Korper & Council, 2002) These changes are likely to place increased pressure on health care services and the demand for social services. It will be important for the Department and the services system to plan for the accelerated growth of the elderly population and their proportionately greater and more expensive healthcare needs.

According to *Mental Health: A Report of the Surgeon General* (1999), almost 20 percent of the population 55 and older, or an estimated 281,940 Virginians (2000 Census), experience specific mental disorders that are not part of "normal" aging. Best estimate one-year prevalence rates for specific mental disorders, based upon epidemiological catchment area information described in the *Surgeon General's Report,* follow.

Estimated One Year Prevalence Rates in Virginia of Mental Disorders Not Associated with Aging Based Upon Epidemiological Catchment Area Information

Disorder	Percent	Number	Disorder	Percent	Number
Any Anxiety Disorder	11.4	162,329	Somatization	0.3	4,271
Any Mood Disorder	4.4	62,653	Severe Cognitive Impairment	6.6	93,980
Schizophrenia	0.6	8,543	Any Disorder	19.8	281,940

Mental Health: A Report of the Surgeon General, Chapter 5 Older Adults and Mental Health (page 336), Source of prevalence estimates: D. Regier and W. Narrow, personal communication, 1999.

Abuse of alcohol and legal drugs, prescription and over-the-counter, is currently a serious health problem among older Americans, affecting up to 17 percent of adults aged 60 or older. Additionally, approximately 50 percent of the elderly are light or moderate drinkers, and the interactions between alcohol and other drugs and multiple drug use may result in significant problems for them. (Adams, 1997, CSAT, 1998) Alcohol and drug use may elevate older adults' already high risk for injury, illness, and socioeconomic decline. (Tarter, 1995) For example, older adults who "self-medicate" with alcohol or prescription drugs are more likely to characterize themselves as lonely and to report lower life satisfaction. (Hendricks et. al., 1991) Older women with alcohol problems are more likely to have had a problem-drinking spouse, to have lost their spouses to death, to have experienced depression, and to have been injured in falls. (Wilsnack and Wilsnack, 1995)

Alcohol and prescription drug misuse and abuse occur among older adults for a variety of reasons. More drugs are prescribed for more chronic illnesses, and older adults may misuse drugs due to confusion, lack of judgment or miscommunication. Because of insufficient knowledge, limited research data, and hurried office visits, health care providers tend to overlook substance abuse and prescription drug misuse among older people, mistaking the symptoms for those of dementia, depression, adverse drug reactions or other problems common to older adults. In addition to the psychosocial issues that are unique to older adults (unresolved loss, progressive family and social isolation, sensory deterioration), age-related biomedical changes influence the effects that alcohol and drugs have on the body and may accelerate the normal decline in physiological functioning that occurs with age. (Gambert and Katsyoannis, 1995)

The *Surgeon General's Report* estimates that an *unmet* need for mental health services may exist for up to 63 percent of adults aged 65 years and older with a mental disorder (p. 341). Also, many older adults need treatment for alcohol and drug abuse disorders and do not receive it; they may be more likely to hide their substance abuse and may be less likely to seek professional help. (CSAT, 1998) Nationally, annual substance abuse treatment admissions among persons 55 or older decreased by 3 percent from 1994 to 1999. During that same time period, U.S. alcohol abuse admissions among older adults declined, but admissions for misuse of illicit drugs increased. (DASIS, 2001) CSB 4th quarter performance contract utilization data indicate that individuals age 65 and older have consistently accounted for less than one percent of the individuals served through Virginia's publicly-funded system of care (510 individuals [0.91 percent] in FY 1993, 512 individuals [0.78 percent] in FY 2000).

The provision of mental health, mental retardation, and substance abuse services to older adults is complicated by the lack of providers trained to serve this population and the limited number of specialized community-based programs in Virginia that serve older adults. The growing need to better serve older adults, including those with mental disabilities, represents a shift in this culture's perspective on older persons. Where society once assumed that older adults required no more than custodial or end-of-life care, increased longevity; a renewed respect for the social, political, and economic contributions of this population; and the demand for more appropriate treatment choices by individuals who receive services have placed

pressures on service delivery systems to develop new treatment models. Treatment models for elderly persons with mental disabilities must be well coordinated, respond to the unique needs of a population with growing health issues, and provide services that promote new roles for individuals who seek to continue as productive members of their communities.

Integrating behavioral healthcare into primary care and other generalist settings will benefit older adults with substance abuse disorders or milder cases of substance dependence. Clearly, a great number of older adults with substance use disorders could be identified through substance screening procedures in primary care or other generalist settings. Large numbers of these older adults could benefit from brief interventions delivered by physicians, nurses, pharmacists, and social workers that interact with them on a regular basis, sometimes in their own homes.

In July 2003, the Department established the Gero-Psychiatric Special Populations Work Group to develop a strategic plan for the development of needed services and support for this population. This Work Group is reviewing the entire system of public gero-psychiatric care in order to assess the sufficiency, comprehensiveness, and coordination of services. For example, while every community in Virginia is served by an Area Agency on Aging that assists with services to older adults, generally, there is no administrative body responsible for integrating the array of services needed specifically for elderly individuals with severe mental illnesses. The Work Group also is reviewing a variety of potential treatment models for statewide development, including mobile consultation/treatment teams, specialized community-based services, specialized nursing facility services with augmented staffing levels, and separate gero-psychiatric residential facilities that provide assessment and treatment.

During FY 2004, the Gero-Psychiatric Work Group will focus primarily on gathering and reviewing data that will identify service needs for this population. This will include compiling data from existing databases and identifying additional data needs. The Work Group will use the data to describe needs and formulate recommendations for improving the current system of services. A secondary initiative during FY 2004 will be the development of an educational program for direct caregivers. Since it is well established that caregiver approaches to elderly patients can affect patient response and treatment outcomes, the program will use a behavior modeling method for improving caregiver skills. The initial program will concentrate on the behavioral skills of direct caregivers who work with patients with dementia. The Work Group is aware that a broader educational approach will be needed, and future programs will address multiple audiences, using multiple media.

Forensic Population Work Group

According to research cited in the President's New Freedom Commission on Mental Health Report, about 7 percent of all incarcerated individuals have a serious mental illness, a rate that is about three to four times that of the general U.S. population. The Report states that those individuals who come into contact with the criminal justice system are often poor, uninsured, disproportionately representative of minority populations, homeless, and living with co-occurring substance disorders and mental illness. They are likely to continually recycle through the mental health, substance abuse, and criminal justice systems. When they are incarcerated, these individuals frequently do not receive adequate mental health services and have difficulty re-entering and reintegrating into the community after discharge because many of them lose income supports and health insurance benefits. A similar situation exists for youth with serious emotional disturbances who are in the juvenile justice system.

The Department supports a number of programs providing mental health and substance abuse services for adults in local and regional jails and children and adolescents in juvenile detention centers. The *Code of Virginia* requires that CSBs maintain written agreements with courts and local sheriffs relative to the delivery and coordination of services (§ 37.1-197). CSBs provide emergency services to individuals in local and regional jails and juvenile detention centers.

Emergency services include evaluations and pre-screening for hospitalization. CSBs also conduct non-emergency evaluations, including evaluations of competency to stand trial, criminal responsibility, and waivers of juvenile court jurisdiction. Many CSBs also provide mental health and substance abuse services to the offender population through local initiatives developed jointly with local and regional jails and juvenile detention centers. These services include: individual and group mental health and substance abuse counseling; psychiatric services, including medication; and restoration to competency.

The Department uses federal SAPT block grant funds to support one substance abuse case manager in each CSB to identify cases and provide assessments and counseling to offender populations. An initiative involving five CSBs provides substance assessment, case identification, crisis stabilization, and linkage to community programs after release for juveniles in detention centers. Nine CSBs receive funds to provide intensive substance abuse treatment patterned after offender-based therapeutic communities in separate jail living areas. CSBs also provide services through 10 adult and two juvenile drug courts to non-violent felons who are offered this as an alternative to incarceration and treatment in jail. Drug courts combine long-term (12-18 months), strict, frequent supervision by probation staff, intensive drug treatment by clinicians, and close judicial monitoring by the court.

Approximately 25 percent of the patients in state mental health facilities have been admitted from courts and jails or juvenile detention centers for treatment or evaluation. Of these, roughly 12 percent have active status as pretrial or post sentence jail inmates and 13 percent are found not guilty by reason of insanity. In FY 2003, 1,036 adult jail inmates and juvenile detention center residents were treated or evaluated in state mental health facilities. While there will always be a subgroup of jail residents who will need acute inpatient treatment, many inmates with mental health or substance abuse problems can be managed on-site in jail settings, provided that the necessary services are available in those locations.

These efforts fall short of the mental health and substance abuse service needs of individuals in Virginia's criminal justice system. For many years, state mental health facilities, due to operational realities have found it necessary to maintain waiting lists for the admission of forensic patients for evaluation and treatment. There are approximately 50 such individuals waiting for admission at any given time. The Department is committed to the development of an appropriate continuum of community-based solutions to resolve the problem of prolonged waiting times for admission of jail inmates for treatment at some state mental health facilities. However, resources necessary for such interventions do not exist.

The process of managing insanity acquittees who have been conditionally released needs to be enhanced in order to prevent readmission of these individuals to state mental health facilities. Additionally, the capacity of CSBs to provide restoration to competency services in jails and community settings should be enhanced. Options include development of jail-based MH/SA teams to improve access to treatment, including medications, in jail settings and development of appropriate community-based care for individuals involved with the criminal justice system who do not present public safety risks. These options are of particular interest to the Committee Studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders

Agreements between jails or detention centers and CSBs for the coordination and delivery of services also need to be strengthened. Enhanced coordination is needed among jails or detention centers and CSBs regarding pre-release planning, communications, and continuity of care to assure rapid connection to community services upon release. Such agreements are critically important because statutory responsibilities for the provision of treatment services to adult and youth offenders are not defined clearly. Currently, no entity at the state or local level has clear responsibility for the provision of these services to adult or youth offenders. The *Code of Virginia* requires that sheriffs provide all necessary health care for jail inmates. The *Code* does not stipulate that jails are responsible for providing their own mental health and substance abuse services, as it does for the Department of Corrections. However, the Virginia

Administrative Code, § 6VAC15-40-1010, stipulates that jail operators must have written policies in place, including agreements for use of either CSBs or private contractors to provide mental health services to inmates.

Additionally, standards for what mental health and substance abuse services should be available to adult and youth offenders across Virginia are lacking, especially in the areas of:

- Assessments to determine the presence of any mental illness, serious emotional disturbance, or substance use disorder and the most appropriate service dispositions for specific offenders;
- Diversion services for nonviolent adult and youth offenders;
- Treatment services provided in jails and detention centers; and
- Post-release treatment services, including specialized services such as supervised living programs.

State mental health facilities provide the following services to adult and juvenile offenders:

- Evaluation of competency to stand trial,
- Evaluation of criminal responsibility,
- Emergency inpatient treatment prior to trial,
- Treatment to restore competency to stand trail,
- Emergency treatment after conviction and prior to sentencing, and
- Emergency treatment after sentencing but prior to transfer to the Department of Corrections (DOC).

The overriding goal of the Forensic Special Populations Work Group is to overcome, to the extent possible, the criminalization of adults with serious mental illnesses and youth with serious emotional disturbances. Subsidiary goals include:

- Fostering the development community-based forensic evaluation and treatment services for those individuals who cannot be diverted from criminal justice system involvement;
- Reducing or eliminating prolonged waits for hospital admission for forensic evaluations and treatment that must be accomplished on an inpatient basis; and
- Defining improved methods for the delivery of a satisfactory array of psychiatric and substance abuse treatment in jail settings.

The activities of the Forensic Work Group will be focused on:

- Reviewing successful approaches that are currently in place around the Commonwealth for the treatment of individuals with mental illness and substance abuse disorders who are involved in the criminal justice system;
- Considering the applicability of nationally-recognized innovative approaches to community-based treatment of individuals in this category; and
- Developing a consensus-based set of recommendations for the Department's Restructuring Policy Advisory Committee.

Draft initial Work Group recommendations include:

- Continue to work in concert with the legislative Task Force Addressing Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders.
- Support current independent local or regional initiatives, including the Jail Services Team that will provide psychiatric treatments to inmates in several Central Virginia jails, the Crisis Intervention Teams (CIT) developed in the Roanoke and Pulaski County regions, and the planned Mental Health Court program in Norfolk.
- Endorse the concept of designating community-based psychiatric facilities as proper treatment sites for non-violent criminal defendants in need of acute care.

- Ensure the continued availability of community-based forensic evaluations by providing support and strengthening the Department's Forensic Evaluation Training Program with the University of Virginia Institute of Law, Psychiatry, and Public Policy.
- Facilitate and encourage the use of community evaluators by the courts.
- Develop procedures for completing outpatient evaluations for the courts and continue to work to divert evaluations to community providers, whenever appropriate.
- Follow-through with current efforts to identify ways a means for providing court-ordered treatment services in jail settings to eliminate delays in accessing treatment services and provide enhanced continuity of care for individuals returning from state hospitals to jails.
- Facilitate the availability of outpatient community-based restoration to competency treatment for nonviolent defendants with mental retardation who do not require incarceration, including training to CSBs in psychoeducational aspects of competency restoration and publishing a training manual on competency restoration developed by a special Department-CSB expert work group.

Mental Retardation Population Work Group

The Mental Retardation Special Populations Work Group is exploring methods to restructure the mental retardation services system. The Work Group reviewed prior recommendations of various groups, including the Olmstead Task Force, the Mental Retardation Waiver Task Force, the 2002 Virginia Association of Community Services Boards conference, and the initial Restructuring Policy Advisory Board meeting brainstorming session. Many of these recommendations were similar and generally fell in three categories: building community capacity, serving challenging people with a dual diagnosis of mental retardation and mental illness (MR/MI); and funding.

The Work Group identified the following services system strengths.

- The State receives federal Medicaid dollars, so most general fund dollars spent on MR services are reimbursed at just over a 50 percent match rate.
- The General Assembly allocated funding for 175 new MR Waiver slots in FY 2004 to reduce the "urgent" waiting list.
- Dedicated and hard working services system staff.
- The many advocates and supporters of people with mental retardation and other disabilities in the State who make mental retardation service issues more visible to politicians and the general community.
- The fact that Virginia's per capita income is high compared to other states.

Work Group members recognized the opportunity that exists in the Department's "restructuring" approach to improving service delivery through greater collaboration among state facilities, CSBs, private providers, and advocates.

The Work Group's initial meeting produced a list of issues that need to be addressed. Members also developed a number of recommendations for restructuring the mental retardation system of care. With respect to building community services and support capacity, the Work Group identified the following problem areas.

- *Issues Related to ICF/MR Eligibility* – CMS is currently looking at the eligibility of some ICF/MR residents and has been decertifying units in North Dakota, Ohio and California. These units are serving individuals who are higher functioning and also have a dual diagnosis or forensic issues, which were the main reason they were admitted to the ICF/MR facility. The premise is that although the facilities are adequately addressing their significant treatment needs, these individuals did not meet the basic training requirements for ICF/MR level of care in areas such as toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs.

- *The "Disconnect" Between Federal Medicaid Regulations and the Olmstead Decision* – Medicaid does not recognize the "least restrictive environment." Additionally, a Florida case has affirmed that ICF/MR placement is an entitlement while Waiver placements are not.
- *Lack of Consistent State Strategy for Addressing Service Needs* – There is no overriding state philosophy that crosses agencies to address needs.
- *MR Waiver Waiting List Definitions* – The current MR Waiver "urgent" waiting list definition does not include people living in facilities. State training center residents who choose community placements would not be eligible for new funding targeted to reduce the "urgent" waiting list. However, separate budget requests could be made for this group of residents.
- *Issues Related to Staffing* – Virginia lacks sufficient numbers of professionals to provide support services in the community. In Northern Virginia, NVTC professionals are providing services to the community through the Regional Community Support Center, but these services are not reimbursable by Medicaid.
- *Issues Related to Providers* – The low reimbursement rate and slow payment of MR Waiver service providers is forcing some providers to close.
- *Lack of Transition Services* – Increasing numbers of children are aging out of services funded by the Comprehensive Services Act. Many of these children are being served in out-of-state placements because there are no services appropriate for them in Virginia. When they age out of CSA services provided out of state, they have few placement options available to them in Virginia.
- *Issues Related to Guardianship* –The lack of sufficient numbers of legally authorized representatives available to assist individuals receiving services.

A goal of the Work Group is to assure that individuals with mental retardation will be served appropriately, regardless of their level of support and treatment needs or eligibility for any particular funding source. To achieve this, the Commonwealth must build capacity to serve individuals, including those who present special challenges, in the community. Such capacity would divert admissions from state facilities and provide alternatives that would reduce the census of state facilities. Initial recommendations follow.

Short Term:

- Utilize existing identified expertise in the community to support discharge planning, transitioning, and community integration.
- Utilize the current climate to maximize cooperation and collaboration across state government Secretariats, agencies, and regions.
- Ensure that individuals receiving services, advocates, and providers are partners in the improvement process.
- Establish a statewide central clearinghouse that includes lists of professionals with a passion to meet the special needs of challenging populations to share effective tools and technologies that have been developed.
- Implement service safety nets for persons.
- Evaluate regional successes as possible strategies for replication.
- Identify "public policy" strategies that are needed to achieve desired outcomes; for example, legislative action that mandates annual allocations to meet growing demands.

Long Term:

- Adequately fund the community-based system through adoption of public policy to maintain services with annual increases for the cost of doing business. Seek sufficient funding for community-based services to achieve a 7th place ranking nationally.
- Re-establish the Department as lead agency in developing policy for the mental retardation service system.

- Allocate funds to the Department to address "crises" and needs not addressed through the Waiver.
- Increase MR Waiver rates to ensure a provider base and manpower model.
- Streamline documentation and regulatory requirements and ensure implementation of these requirements.
- Develop a single, seamless service delivery system.
- Build incentives into the services system to serve persons with special challenges (e.g., supplemental reimbursement for additional supports).
- Ensure consistency across the regulatory requirements of the Department and its sister agencies (e.g., DMAS and Department of Social Services).
- Develop a community and legislative "public relations" effort.

Work Group recommendations for serving challenging people with dual diagnoses of mental retardation and mental illnesses follow.

Short Term:

- Build mental health services capacity to serve persons with co-occurring mental retardation. Regional efforts have identified resources to assist and train willing professionals immediately.
- Ensure that persons treating an individual with both MR and MI diagnoses possess appropriate skills.
- Build on existing strengths by establishing a central clearinghouse to make information about resources available statewide, by using creative approaches, and by considering strategies brought to the table by grass root efforts.
- Use an approach that results in an array of options.
- Partner with advocacy groups such as The Arc of Virginia, the Coalition for Mentally Disabled Virginians, NAMI-Virginia, and the Virginia Board for People with Disabilities to support efforts to meet this challenge.

Long Term:

- Adequately fund the community-based system to reduce the census of state facilities and eliminate waiting lists for services through multiple funding sources, not just the MR Waiver.
- Engage in long term planning that maximizes resources into a single seamless system.
- Address MR/MI population challenges, including housing, systemically.
- Work to develop outcomes that are realistic and can be implemented.
- Consider a more mobile, flexible, specialized role for state facility staff in the future
- Develop supports for persons with medical needs, aging individuals, and their aging caregivers.

The lack of timely access to services can have the following negative effects on individuals and their families, as well as significant dollars ramifications, for the services system.

- *Individual and Family Crises* – Expensive crisis management involves crisis intervention staff, emergency room services, law enforcement; courts, and jails
- *Poor Outcomes for Individuals and Families* – Access to services brings many individuals to levels of functioning that enable them to contribute to society. This is especially important for young adults who have nothing waiting for them after the school system stops serving them. Additionally, the family member may have to stop working to provide care.
- *Potential for Abuse and Neglect* – Stresses on the family increase the incidence of abuse and neglect
- *Lack of Equal Access to Services* – Existing variations in access to services across the state place people in rural areas at a great disadvantage in accessing certain services.

- *Reliance on State Training Centers* – The lack of funding for community-based services places additional burdens on state-operated facilities, which ultimately will have an impact on the State.

The Work Group believes that service funding for persons with MR is exclusively a state responsibility and function that should not be shifted to localities. The state should establish predictable annual increases in funding (to reflect population growth, population needs plus inflation) in order to allow for effective management of the waiting lists and provider development.

Substance Abuse Population Work Group

The Substance Use Disorder Special Population Work Group met on August 11, 2003 to begin its strategic planning. Results of the Work Group discussion follow:

Services System Strengths:

- The Department's Adult and Adolescent Substance Abuse Diversion Projects and the Acute Care Project in Region-IV have diverted the majority of those individuals who had a presenting substance use disorder diagnosis from admission to state psychiatric facilities.
- For those individuals with substance use issues who are admitted to state facilities, once stabilized, the Census Management component of the Substance Abuse Diversion Project has enabled a speedier return of these individuals to community care.
- Support for models integrating MH/SA services and co-occurring disorders as well as pilot projects, such as the Courtland Center Crisis Stabilization Project, indicate a willingness to look at new innovative ways to address service delivery issues and systems.

Services System Weaknesses/Challenges/Barriers

- There are many challenges facing the service delivery system, including; a lack of uniform diagnostic criteria for determining co-occurring disorders, a lack of focus on the continuum of care for adolescents, the lack of public co-occurring treatment facilities for adolescents and adults and a lack of community treatment capacity and supports.
- Financial challenges facing the treatment system include diversion dollars that have remained constant while the costs for purchasing these services have significantly increased and substantial (10 to 15 percent) reductions in state general funds last year, which generally reduced services and reduced funds specifically for diversion.
- There is a perception that diagnostic practices vary considerably among state facilities.
- Current reinvestment plans do not fully address the treatment needs of the co-occurring population.
- Funding issues present a major barrier to co-occurring clients.
- The lack of Medicaid reimbursement presents a barrier to receiving appropriate services.

Existing opportunities for improvement

The Department’s reinvestment and restructuring processes present a unique opportunity for services that currently do not exist or are provided in a facility setting to be moved, transferred or established within the community. The system needs to take advantage of available grant opportunities.

Policy/administrative actions

The Department’s reinvestment and restructuring processes should begin to target the treatment needs of individuals with co-occurring mental health and substance use disorders.

Funding/service development actions

The work group proposed three recommendations.

- ❍ Support plans to use reinvestment dollars to support crisis stabilization services as the hub of community services for persons with co-occurring disorders.
- ❍ Target future reinvestment dollars to new specialized services in areas such as housing, case management, and adolescent services.
- ❍ Recognize, in the Virginia Medical Assistance Plan, the cost effectiveness of covering the continuum of Substance Use Disorder services.

Promoting a Flexible and Seamless System of Specialized Care

Few CSBs have available the range of expertise that may be required to meet the specialized service needs of many individuals who will be discharged or diverted from hospitalization in the coming years, particularly those who may require a more flexible and adaptive approach to medical planning with a menu of available medical resources within a broad continuum of care. This shortage of specialists is especially critical in rural areas where the need for such services may not warrant a full-time practitioner and where funding or the shortage of trained manpower makes it difficult to recruit specialists. By contrast, state facilities have pools of trained specialists in geriatric medicine, child psychiatry, psychopharmacology, forensic psychiatry, applied behavior analysis, and other areas of expertise.

The Department is developing strategies for utilizing this pool of state facility medical expertise to provide outreach for treatment, training, education, and consultation in CSBs. The objective is to make this highly specialized expertise available to community providers when and to the extent it is required, thus improving the availability and quality of services and ensuring greater continuity in the care that is provided.

Goals, Objectives, and Action Steps

Goal 1: Transform Virginia's services system to better meet the needs of individuals with mental illnesses, mental retardation, and substance use disorders and their families.

Objectives:

1. Develop a more comprehensive and fully developed system of community-based care that provides an expanded array of quality services and supports closer to where people live.

Action Steps:

a. Seek funding to develop community-based emergency, rapid assessment and referral, and crisis stabilization services and purchase acute inpatient psychiatric care in community hospitals as alternatives to inpatient treatment.

b. Continue to work with the regions to successfully implement the three Regional Reinvestment Projects and any future Regional Reinvestment Projects proposed by the Regional Partnerships.

c. Implement systems to document performance of the three Regional Reinvestment Projects and any future Regional Reinvestment Projects.

d. Support ongoing Regional Partnership Planning activities.

e. Work with services providers and the advocacy community to develop services and supports that focus on recovery and resilience rather than the management of symptoms of mental illness and substance use disorders.

f. Support efforts of the regions to develop "step-down" and "step-up" services such as transitional housing for individuals who have been discharged from an inpatient setting or who are at risk of inpatient admission.

g. Support efforts of the regions to identify and implement clinical and revenue enhancing practices that do not require additional state funding resources.

h. Support efforts of the regions to develop regional services.

i. Explore Medicaid waivers and other options with the Department of Medical Assistance Services (DMAS) to increase flexibility in financing and eligibility policies and in service requirements.

j. Work with Department staff and other agencies such as DMAS to address and resolve policy, administrative practice, funding, and service delivery issues that present barriers to the successful implementation of Regional Partnership plans.

2. Facilitate local and regional collaborative management of publicly funded inpatient services so that all admissions to any inpatient setting are appropriate, acute care is monitored, and post-discharge services are provided.

Action Steps:

a. Support efforts of CSBs and state facilities in each region to develop or expand regional inpatient authorization and utilization management processes.

b. Engage in dialogues through the Regional Partnerships and at the state level with private psychiatric hospitals regarding opportunities for enhanced collaboration in managing the delivery of publicly funded community-based inpatient services.

3. Remove barriers between state facility and community services.

Action Steps:

a. Support efforts of the regions to improve continuity of care between state facilities and CSB programs.

b. Make unused state facility buildings available for community-operated regional services.

c. Work with the Regional Partnerships to develop memoranda of agreement defining the scope, responsibilities, and operational procedures for shared or "blended" community and state facility services and staff.

4. Foster partnerships among CSBs, state facilities, private providers, individuals receiving services and families, and other services system partners in Reinvestment and Restructuring activities.

Action Steps:

a. Seek advice and input on statewide policy issues and strategic directions from services system partners through the Restructuring Policy Advisory Committee.

b. Provide resources to support involvement of individuals receiving services and family members in Regional Partnership planning activities.

c. Encourage Regional Partnerships to include a broad representation of local and regional partners on their steering committees and to provide multiple opportunities for input and feedback.

Goal 2: Address the special service and support needs of child and adolescent, gero-psychiatric, forensic, mental retardation, and substance abuse populations.

Objectives:

1. Develop, through the Special Populations Work Groups and in collaboration with key services system partners, strategic plans for state and local and regional actions to respond to the needs of the identified population groups.

Action Steps:

a. Complete assessments of population-specific services and support needs, issues, challenges, and opportunities.
b. Recommend strategies for implementing needed services and supports for consideration by the Restructuring Policy Advisory Committee and the Department.
c. Recommend state-level policy, regulatory, funding, and administrative actions for consideration by the Restructuring Policy Advisory Committee and the Department.

Goal 3: Promote the development of a comprehensive array of specialized prevention and treatment services and supports for elderly persons with mental and substance use disorders.

Objectives:

1. Develop a comprehensive, community-based continuum of mental health, mental retardation, and substance abuse services for older Virginians.

Action Steps:

a. Work with CSBs, community providers of aging services, and community organizations to raise their awareness of the mental health, mental retardation, and substance abuse service needs of older Virginians.
b. Provide technical assistance and training on service models that respond to the mental health, mental retardation, and substance abuse service needs of older Virginians.
c. Explore potential financial resources for the development of individual-centered, family-focused community-based services for older adults that reflect best practices.
d. Explore service models that would assist community nursing home and assisted living facility operators to effectively manage defined targeted behaviors, such as wandering and aggression, which routinely result in expulsion from nursing homes and ALFs.
e. Explore the feasibility of implementing a gero-psychiatric pilot program or programs that would test and monitor outcome measures on a limited scale and allow for comparative analyses among various residential models, such as a nursing home with a dedicated wing or a separate residential facility.
f. Work with DMAS to establish a support model, as opposed to a habilitation model, for older individuals who are receiving MR Waiver services.

Goal 4: Promote the establishment of an integrated system of service delivery that is responsive to the mental health, mental retardation, and substance abuse needs of children and adolescents and their families.

Objectives:

1. Take steps to implement the continuum of mental health, mental retardation, and substance abuse services for children and adolescents.

Action Steps:

a. Seek funding to develop new and expand existing child and adolescent services necessary to fill gaps and build community capacity, including funds for program start-up, services needed by individuals with co-occurring disorders, children with early development needs, juvenile sex offenders, and adolescents who are transitioning into the adult services system.
b. Explore resources to provide integrated training and peer-to-peer consultation among CSBs on evidence-based programming and other successful service models.
c. Explore the feasibility of increasing the Medicaid EPSDT rate for services and expanding covered diagnoses.

d. Seek funding to increase the number of board-eligible or certified child psychiatrists for CSBs.

e. Work with universities to establish child psychiatry fellows and doctoral interns in clinical psychiatry at CCCA and SWVMHI and develop a plan for building statewide capacity for these disciplines.

2. Continue to work to improve access by children and adolescents and their parents to mental health, mental retardation, and substance abuse services.

Action Steps:

a. Continue to support the efforts of the workgroup established by the Department to identify service needs and update the integrated policy and plan required by Item 329-G of the 2000-2002 Appropriation Act.

b. Develop annual integrated policy and plan updates, as required by Item 329-G.

c. Seek ways to build and link the network of parents of children and adolescents with mental health, mental retardation, and substance abuse services.

d. Establish a state advisory committee for child and family services to support the activities of the Department's Office of Youth and Family Services.

e. Establish an interactive web site that can serve as a resource for parents and youth.

3. Work to improve residential supports provided to children who are medically fragile.

Action Steps:

a. Continue to provide needed supports and services to maintain children in their homes.

b. Explore the availability of interested providers who are willing to develop residential models to serve medically fragile children.

c. Work with community providers to explore the development of community ICF/MRs for children.

d. Explore with DMAS the potential for developing a separate Medicaid waiver for children's services.

Goal 5: Enhance Virginia's capacity to intervene and divert individuals with mental illnesses and substance use disorders from the criminal justice system and enhance the capacity to provide mental health and substance abuse evaluation and treatment services to individuals involved with the criminal justice system.

Objectives:

1. Develop an appropriate continuum of jail and community-based mental health and substance abuse services for individuals involved with the criminal justice system.

Action Steps:

a. Seek funding to expand the number of jail-based mental health and substance abuse teams, improve access to medications, and develop other appropriate community diversion and post-release services.

b. Improve and streamline the process of managing insanity acquitees who have been conditionally released.

c. Enhance the capacity of CSBs to provide restoration to competency services in jails and community settings.

2. Implement, to the extent possible, national and state service models that represent best practices in areas such as crisis teams, assessments and diagnostic services, early identification procedures, treatment services, pre-release planning, assertive case management, post-release services, and drug courts.

Action Steps:

a. Incorporate national and state service models into long-range interagency planning activities.

b. Provide training and technical assistance to criminal justice and mental health, mental retardation, and substance abuse services staff on national and state service models.

c. Identify, and where appropriate, seek funding to implement these service models across the Commonwealth.

3. Strengthen state and local collaboration necessary to provide an effective continuum of care for adult and youth offenders with mental health and substance abuse service needs.

Action Steps:

a. Continue to collaborate with the Departments of Criminal Justice Services (DCJS) Juvenile Justice (DJJ), and Corrections (DOC) in ongoing strategic planning, policy, and service development efforts.

b. Provide technical assistance to CSBs, jail and detention centers, sheriffs, and courts in the development of local memoranda of agreement that clarify goals, define responsibilities, and outline specific activities and tasks, including procedures for accessing treatment in jails and detention centers, and identification of case managers responsible for coordinating continuity of care across the systems.

c. Monitor the status of memoranda of agreement between criminal justice and treatment agencies.

d. Encourage participation of CSBs on local drug court planning and implementation committees.

e. Provide training in mental illness and substance abuse to criminal justice professionals and in criminal justice issues to mental health and substance abuse professionals.

f. Implement interagency initiatives as resources become available.

4. Provide timely forensic evaluation and treatment services in the most appropriate settings that meet but do not exceed the level of intervention needed to provide necessary treatment and maintain public safety.

Action Steps:

a. Continue to work with CSBs to expand their capacity to provide forensic evaluation services in the community.

b. Continue to provide training and technical assistance to CSBs to enhance their management of insanity acquittees who have been conditionally released.

c. Seek funding to establish sub-acute residential programs for individuals receiving forensic treatment in state facilities who no longer need an inpatient level of services.

d. Continue to streamline and improve the Department's Forensic Review Panel privilege-granting process for state facility forensic patients who meet certain criteria.

5. Develop new and maintain and expand existing treatment opportunities in communities and institutional settings for individuals with substance use disorders who are involved with criminal justice agencies.

Action Steps:

a. Pursue grant opportunities for delivery of services to offender populations.

b. Continue to provide technical assistance to CSB services provided in jails and detention centers to adults and juveniles.

c. Monitor the Adult and Adolescent Detention Projects.

Goal 6: Strengthen the services delivery system for people with mental retardation by restructuring some traditional approaches to services in the community and in state facilities.

Objectives:

1. Support the implementation of the recommendations of the Mental Retardation Special Populations Work Group.

Action Steps:

a. Seek funding to develop MI/MR regional and clinical emergency support teams.

b. Develop plans with specific action steps for resolving existing barriers to the successful implementation of the Work Group's short and long-term recommendations.

c. Review, on an annual basis, the number of Work Group recommendations that have been implemented and determine what additional actions are feasible.

Goal 7: Make state facility medical and clinical expertise in geriatric medicine, child psychiatry, psychopharmacology, forensic psychiatry, and applied behavior analysis available to CSBs when and to the extent it is required.

Objectives:

1. Develop a system that uses state facility medical and clinical expertise to provide consultation and assistance to CSBs in rural and clinically underserved areas.

Action Steps:

a. Convene a workgroup of state facility and CSB leaders to identify current and projected areas of service need.

b. Assess the capacity of current medical and clinical staff to meet the specialized service needs of individuals served by CSBs in rural and clinically underserved areas.

c. Identify the availability of specialized medical and clinical expertise in state facility programs by state facility service area.

d. Develop strategies to provide state facility specialized medical and clinical staff for treatment and consultation services to CSBs that have current and projected shortages.

e. Use state facility medical and clinical specialists to provide training to CSB personnel in identified areas of need, using interactive telecommunication networks and video technology.

Improving Access to Community-Based Services in a Restructured System of Care

Olmstead Task Force Report Recommendations

In 1999, the United States Supreme Court issued a decision in the case of Olmstead v. L.C., 119 S. Ct. 2176 (1999). This case involved a challenge under Title II of the Americans With Disabilities Act (ADA), 42 U.S.C. § 12132, by two women with mental disabilities who lived in mental health facilities operated by the state of Georgia, but who wished to live in the community. The ADA prohibits discrimination in public services furnished by governmental entities (Title II, 42 U.S.C. § 12131-12165). Title II regulations issued by the U. S. Attorney General include an integration regulation stating: "A public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The most integrated setting is that which enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible. The U.S.

Supreme Court held that Georgia had violated the ADA by forcing these women to remain in a state mental hospital after their treating professionals had determined that they were ready for discharge.

In the decision, the Court held that a State is required under Title II of the ADA to provide community-based treatment for persons with mental disabilities when:

- The State's treatment professionals determine that such placement is appropriate;
- The affected persons do not oppose such placement; and
- The placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with disabilities.

Although the Olmstead case involved two individuals with a mental disability, the decision is broad in its scope and applies to all qualified persons with disabilities covered by the ADA. It applies to all qualified individuals with mental, physical, or sensory disabilities. It applies to individuals who are institutionalized or who are at risk of institutionalization.

The Olmstead decision does not prohibit institutional placement, but, in fact, recognizes it as the least restrictive setting for some individuals who cannot handle or benefit from community settings. Additionally, the decision affirms that there is no federal requirement that imposes community-based treatment of patients who do not desire it.

States must make reasonable accommodations in programs in order to provide community-based services to qualified individuals, unless doing so would fundamentally alter the services provided. This "fundamental alteration" standard is met if the state can demonstrate that it has:

- A comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and
- A waiting list that moves at a reasonable pace not controlled by the state's efforts to keep its institutions fully populated.

In evaluating a State's fundamental alteration defense, the courts must consider, in view of the resources available to the State: the cost of providing community-based care; the State's responsibility for maintaining a range of facilities for the care of persons with diverse disabilities; and the State's obligation to mete out services equitably. A simple comparison of the cost of providing care for individuals in the community with the cost of institutional care is not sufficient.

In Item 329 M of the 2002 Appropriation Act, the General Assembly directed the Department to convene a task force to "develop a plan for serving persons with disabilities that implements the recommendations of the Olmstead decision (Olmstead v. L.C., 119 S. Ct. 2176 [1999])." Virginia's Olmstead Task Force was chaired by Secretary Woods and had 70 members representing individuals with disabilities, family members, advocates, providers, local government, members of the General Assembly, and other interested individuals and groups. Fifteen state agencies that provide or oversee services to individuals with disabilities served as members of, and provided resources to support, the Task Force. The Task Force worked from July 2002 to August 2003. Its Final Report was submitted to the Governor, the Joint Commission of Health Care, and the Chairmen of the House Appropriations and Senate Finance Committees on September 15, 2003.

The Task Force examined major issues that cut across populations of individuals with disabilities. Topic areas included:

- Accountability
- Educating the Public, Consumers & Families
- Employment
- Housing
- Prevention &Transition Services
- Qualified Providers
- Transportation
- Waivers.

The Olmstead Task Force Final Report includes a vision, goals statement, and over 200 recommendations organized by implementation time frame and responsible entity. Key

components of the vision are: individual choice; consumer-directed services and supports; accountability to individuals, family members, decision-makers, and the public; sufficient numbers of qualified providers; safe, available, accessible, and affordable housing and transportation; an opportunity to work; and a full continuum of care, from self care through institutional care. The Task Force goal statement states that qualified individuals with disabilities in Virginia must, if they choose, be afforded the opportunity to:

- Move to a more integrated setting appropriate to their needs;
- Stay in the community of their choice once they have moved into a setting that is appropriate for their needs;
- Live successfully in the community of their choice while receiving appropriate services in order to prevent unwanted institutionalization; and
- Work collaboratively with all public and private partners to ensure the implementation of the Olmstead decision.

Recommendations include actions that would have a *direct impact on individuals with disabilities* and actions that provide *systems support*. Each recommendation also contains implementation actions, responsible entities, and a general time frame during which each proposed action would be initiated. Examples of issues and recommendations within the Olmstead Task Force Report follow.

People with disabilities lack sufficient choices of services and supports they need; some have no access.

- Amend Medicaid Waivers, including the MR Waiver, to provide for consumer-directed services; develop Waivers for people with brain injury and dementia.
- Eliminate waiting lists, including the MR Waiver and state facility discharge waiting lists, by 2009
- Expand the availability of crisis stabilization programs.
- Expand the Medicaid State Plan Option service array to include PACT, expanded residential supports, personal assistance, and consumer-directed services.
- More fully address the needs of qualified individuals with mental illness.
- Expand and maximize the use of current expertise and expert models already in place for persons with mental retardation by expanding the Regional Community Support Center (RCSC) concept, now at the Northern Virginia Training Center, to other facilities.
- Increase Medicaid eligibility to 125 percent of the Federal Poverty Level by 2007.
- Develop incentives to increase the number of providers of community services.
- Expand services for students transitioning out of school and people being discharged from institutions.
- Expand adult foster care, regional community support centers for people with mental retardation, and hospice services.
- Use the Department's Restructuring Partnership process as a model to encourage facilities and communities to function in a more integrated manner.

People with disabilities and family members need to be involved in decisions that affect them.

- Appoint more people with disabilities to boards and planning groups.
- Use technology to increase participation and involvement of people with disabilities and their family members.

Consumer rights, health, and safety must be protected.

- Enact legislation requiring community providers to report serious incidents and deaths to the Virginia Office of Protection and Advocacy (VOPA).

- ❍ Create a Division of Licensing from existing licensing entities.
- ❍ Increase the availability of training for public health and safety personnel, mentoring programs, protective services, and surrogate decision-makers.

People with disabilities, family members, providers, and the public must be better educated about disabilities and resources available to individuals with disabilities.

- ❍ Create a statewide resource library and a toll-free number to link people with the resources they need.
- ❍ Provide opportunities for people to volunteer, such as mentoring programs.

People with disabilities do not have sufficient opportunities for employment.

- ❍ Develop a system to facilitate coordination among institutional and community providers to link individuals with disabilities with employment supports.
- ❍ Maximize Federal reimbursements for employment-related services and supports.
- ❍ Remove financial disincentives for people with disabilities who would like to work.
- ❍ Increase the service capacity of existing employment support services for persons with disabilities.

People with disabilities often cannot locate safe, available, affordable, and accessible housing.

- ❍ Provide additional housing subsidies or income supplements, and prioritize the needs of people with disabilities in allocating them.
- ❍ Increase understanding and enforcement of the accessibility requirements of the Fair Housing Act, the ADA, and Section 504 of the Rehabilitation Act of 1973, and modify existing housing stock to meet accessibility needs.
- ❍ Provide a notification system so that people with disabilities receive advance notice of the availability of accessible housing units.
- ❍ Establish alternative funding mechanisms to the current Auxiliary Grant program for subsidizing assisted living services.
- ❍ Maximize the use of Federal Housing Choice Vouchers and Federal deep "project-based" housing subsidies.

Individuals with disabilities need the benefits of research and new knowledge.

- ❍ Strengthen privacy protections for genetic information.
- ❍ Fund disease-or disability-specific research grants.

Individuals with disabilities face transportation barriers.

- ❍ Advocate Federal regulatory revisions to assess per capita allotments fairly within state allocations in distributing transportation funding so that amounts would be allotted equitably among rural and urban populations.
- ❍ Balance expenditures between highways and public transportation.
- ❍ Study the DMAS transportation brokerage system.
- ❍ Overcome physical barriers in community transportation infrastructure, and enforce ADA compliance.

There is a workforce crisis in Virginia and nationally.

- ❍ Use aggressive recruitment, training, and consumer direction of services.
- ❍ Re-title positions “Direct Support Professionals” and provide adequate pay and benefits to retain them.

- ❍ Create one definition for “qualified provider” to be applied by all agencies providing or paying for services and supports.
- ❍ Increase Medicaid reimbursement rates.

Mechanisms to continue Olmstead planning and assure implementation must be created.

- ❍ Require state agencies to collaborate on costing out and implementing the recommendations in the Report.
- ❍ Develop a mechanism to compile waiting list data from nursing homes and assisted living facilities.
- ❍ Designate one person to be charged with monitoring the implementation of the recommendations and a stakeholder group to prioritize them.
- ❍ Retain an “outside system” to organize and analyze existing data and collect additional data for use in future Olmstead planning.

The Olmstead Task Force Report and information about the Olmstead decision and the Task Force is available on the Task Force’s website--“One Community”-- at www.olmsteadva.com.

In response to the Olmstead Task Force Report recommendations, the Governor is working with the Secretary of Health and Human Resources to:

- ❍ Establish a collaborative, multi-agency team to cost out recommendations in the Report;
- ❍ Direct state agencies to implement administrative actions that do not require legislation or funding;
- ❍ Direct agencies to prepare legislative and budget proposals for his consideration; and
- ❍ Establish an Olmstead Oversight Advisory Committee, comprised of individuals with disabilities, family members, advocates, and providers, to monitor implementation of the recommendations, receive annual progress reports from the multi-agency team and advise the Governor on suggested policy and administrative changes.

Community Capacity Development in Response to Documented Demand

Virginians with serious mental illnesses or emotional disturbances, mental retardation, or substance use disorders should receive high-quality treatment and services that:

- ❍ Are appropriate to the individual’s service and support needs;
- ❍ Reflect the individual’s choice and that of his family;
- ❍ Promote recovery, rehabilitation, and self-determination to the greatest extent possible;
- ❍ Provide positive outcomes; and
- ❍ Demonstrate cost-effectiveness.

Services should be provided in the most integrated setting appropriate to the needs of the individual. Services should build on, rather than replace, the individual’s natural supports (family, friends, neighbors, churches, and other community organizations). This includes doing everything possible to keep the individual’s family structure in place for as long as this is possible.

Anyone in crisis due to a mental disability or substance use disorder needs an array of intensive intervention services in the community that provide emergency, short-term local hospitalization, detoxification, and crisis stabilization services, in essence, a services safety net. Such services:

- ❍ Address an immediate crisis that could escalate to a point where the person becomes a danger to himself or others,
- ❍ Prevent a further deterioration in functioning level or life circumstances that could cause the person to need longer-term services,

- Improve an individual's ability to function effectively in personal, work, or school environments, and
- Provide early intervention necessary to prevent, for some individuals, the onset of a life-long mental disability.

Individuals who have the most serious illnesses or severe disabilities also need individualized longer-term services that provide continuing care over longer periods designed to enable individuals to achieve their full potential in all aspects of their daily lives. In a community-based system of care, this includes a full-range of community outpatient and case management, day treatment and rehabilitation, and residential services as well as services provided in state mental health facilities and mental retardation training centers. In addition to services and supports provided or arranged by professionals, non-traditional services and supports such as those provided by individual-operated peer-support programs and services provided in partnership with neighborhood and community organizations also important.

Through concerted efforts by individual and family advocates and services providers, Virginia has worked diligently to establish a comprehensive array of community-based services and to reduce waiting lists for services. However, because of the Commonwealth's budget crisis, this progress has largely stalled. In FY 2002, 192,149 Virginians received mental health, mental retardation, and substance abuse services provided by CSBs, compared to 201,607 individuals served in FY 2000. Department funding to CSBs for community services was reduced by over $12.5 million in FY 2003 and FY 2004 because of the budget crisis.

Although CSBs worked to reduce the impact of these and other state or local funding reductions on individuals receiving services, they could not avoid cuts in direct services. Some programs were eliminated or consolidated. Others experienced staff or service hour reductions. Consequently, CSBs could not provide the level or range of services required by individuals on their caseloads and others who had sought services but were unable to obtain them.

CSB Waiting Lists

The Department asked the CSBs to complete a point-in-time automated database to document the specific service requirements of individuals on CSB waiting lists on April 11, 2003. To be included in the database, an individual had to have sought a service from the CSB and been assessed by the CSB as needing that service. A summary of services needed, individual risk factors or special circumstances, and average service wait times by program area follow. Services are defined in Appendix C.

CSB Mental Health Waiting List Information

Numbers of Individuals on CSB MH Service Waiting Lists by Service
April 11, 2003

Service	Adult	C&A	Service	Adult	C&A
Outpatient Services					
Psychiatric Services	1,760	457	Intensive SA Outpatient	319	43
Medication Management	1,700	411	Intensive In-Home	0	307
Counseling and Psychotherapy	1,836	704	Case Management	1,602	498
Assertive Community Treatment	399	0			
Day Support Services					
Day Treatment/Partial Hospitalization	351	0	Supported Employment Group Model	215	10

Service	Adult	C&A	Service	Adult	C&A
Rehabilitation	691	9	Transitional or Supported Employment	458	36
Therapeutic Day Treatment	0	386	Alternative Day Support Arrangements	310	53
Sheltered Employment	264	8			
Residential Services					
Highly Intensive (MH)	277	46	Supervised	457	17
Highly Intensive (SA Detox)	84	5	Supportive	810	29
Intensive	152	34	Family Support	287	133
Early/Infant-Toddler Intervention					
Infant and Toddler Intervention	0	3			

Of the children and adolescents on waiting lists for CSB mental health services, 1,158 were identified by the CSBs as currently needing specific services, 53 were identified as needing specific services beginning the 2006-2008 biennium, and 103 were identified as needing specific services beginning in the 2008-2010 biennium.

Of the 5,030 adults and 1,344 children and adolescents on CSB MH waiting lists, a number were identified by CSBs as having other disabilities, special circumstances or service needs, or specific risk factors. These follow.

Numbers of Individuals on CSB MH Waiting Lists With Other Disabilities, Special Circumstances or Risk Factors: April 11, 2003

Circumstance/Risk Factor	Adult	C&A	Circumstance/Risk Factor	Adult	C&A
In Jail, Correctional Facility, Juvenile Detention Facility, or Criminal Justice Involvement	213	109	Unable to Communicate with Verbal Speech	41	10
MI/SA and SA/MI Diagnoses	984	50	Traumatic Brain Injury	100	11
MI/MR and MR/MI Diagnoses	174	41	Dementia	88	0
MI/MR/SA Diagnoses	27	2	High or Extensive Physical or Personal Care Needs	404	43
Developmental Disability Other Than MR	129	74	Major Medical Condition/ Chronic Health Problem	1,329	52
Deafness or Hearing Loss	76	7	Limited English Proficiency (National Origin)	254	28
Blindness or Visual Impairment	82	6	Receiving Special Education	0	514
Non-ambulatory or Major Difficulty in Ambulation	144	5	Care Giver Illness or Disability	165	0
At Risk of Being Homeless or Out or Home Placement	948	144	Social Services/Juvenile Justice System Involvement	0	285
Current Residence Is Not Satisfactory or Appropriate to Individual's Needs	635	79	Current Residence Is Satisfactory But Supports Provided are Inadequate	766	386

Circumstance/Risk Factor	Adult	C&A	Circumstance/Risk Factor	Adult	C&A
Currently Unemployed or No Day Support Options	2,076	0	Aging Out of CSA or Foster Care Financing for Residential Services	0	27
Social Supports Are Limited or Lacking	2,627	582	Caregiver Is Unable or Unwilling to Provide Support	0	180
No Guardian or Legally Authorized Representative	269	2	Family Has Petitioned to be Relieved of Custody	0	7
Aging Care Giver	307	82	Currently Truant, Expelled, Suspended, or School Drop Out	0	117

- Social supports were lacking for 52 percent of the adults and 44 percent of the children and adolescents on CSB waiting lists.
- Of the adults on waiting lists, 41 percent were unemployed or lacked day support options.
- For children and adolescents 39 percent were aging out of special education services, 8 percent were in a juvenile detention facility, and 22 percent had social services/juvenile justice system involvement. Almost 9 percent were currently truant, expelled, or suspended or had dropped out of school.
- Nineteen percent of adults were at risk of being homeless. Fifteen percent of adults and 29 percent of children and adolescents resided in a satisfactory setting but lacked adequate supports. The current residence was not satisfactory or appropriate to the needs of 13 percent of adults and 6 percent of children and adolescents. The individual's caregiver was unable or unwilling to provide support for 14 percent of the children and adolescents, with a small number of families having petitioned to be relieved of custody.
- Almost 20 percent of adults on waiting lists had a co-occurring substance abuse diagnosis and 26 percent had a major medical condition or chronic health problem.

CSBs also estimated the number of weeks individuals waited prior to their actual receipt of specific services. Average wait times across the 40 CSBs for specific mental health services follow. The longest service wait times were reported for residential services, with an average wait of just over one year for supervised residential services.

Average MH Service Wait Times in Weeks Across CSBs by Service and Population
April 11, 2003

Service	Adult	C&A	Service	Adult	C&A
Initial Assessment					
Initial Assessment	3.67	3.04			
Outpatient Services					
Medication Management	7.94	4.21	Psychiatric Services	8.61	4.55
Assertive Community Treatment	17.73	N/A	Intensive In-Home	N/A	4.65
Counseling and Psychotherapy	7.20	5.13	Case Management	6.76	3.19
Day Support					
Day Treatment/Partial Hospitalization	5.13	N/A	Supported Employment Group Model	7.11	3.50
Rehabilitation	11.38	2.50	Transitional or Supported Employment	13.42	4.00

Service	Adult	C&A	Service	Adult	C&A
Therapeutic Day Treatment	N/A	6.00	Alternative Day Support Arrangements	20.57	1.00
Sheltered Employment	10.17	12.00			
Residential Services					
Highly Intensive	16.25	5.00	Supportive	34.19	16.00
Intensive	22.14	9.25	Family Support	10.00	5.60
Supervised	52.83	12.50			

CSB Mental Retardation Waiting List Information

Numbers of Individuals on CSB MR Service Waiting Lists by Service and Population
April 11, 2003

Service	MR	Service	MR
Outpatient Services			
Psychiatric Services	131	Intensive In-Home	25
Medication Management	163	Assertive Community Treatment (MR/MI)	16
Behavior Management	122	Case Management	889
Day Support Services			
Rehabilitation (Center and Non-Center Based)	370	Supported Employment Individual Model	259
Sheltered Employment/Prevocational	289	Alternative Day Support Arrangements	154
Supported Employment – Group Model	209		
Residential Services			
Highly Intensive (ICF/MR or Other Specialized)	93	Supervised (Congregate)	406
Intensive (Congregate)	370	Supportive (Supported Living, In-Home, Personal Assistance, Companion Services, Respite)	997
Early Intervention			
Infant and Toddler Intervention	214		
Other Services and Supports			
Nursing Services	56	Environmental Modifications	11
Assistive Technology	78	Personal Response System (PERS)	92
Therapeutic Consultation	110	Family Support Services	173

Of the individuals on waiting lists for CSB mental retardation services, 2,166 were identified by the CSBs as currently needing specific services, 299 were identified as needing specific services beginning the 2006-2008 biennium, and 191 were identified as needing specific services beginning in the 2008-2010 biennium.

Of the 2,656 individuals on CSB MR waiting lists, a number of individuals were identified by CSBs as having other disabilities, special circumstances or service needs, or specific risk factors. These follow.

Numbers of Individuals on CSB MR Waiting Lists With Characteristics That May Require Specialized Services and Supports: April 11, 2003

Circumstance/Risk Factor	MR	Circumstance/Risk Factor	MR
In Jail, Correctional Facility, Juvenile Detention Facility, or Criminal Justice Involvement	23	Unable to Communicate with Verbal Speech	400
MR/MI Diagnoses	313	Traumatic Brain Injury	25
MR/SA Diagnoses	13	Dementia	7
MI/MR/SA Diagnoses	18	High or Extensive Physical or Personal Care Challenges	360
Developmental Disability Other Than MR	432	Major Medical Condition/ Chronic Health Problem	398
Deafness or Hearing Loss	85	Limited English Proficiency (National Origin)	56
Blindness or Visual Impairment	152	Aging Care Giver	369
Non-ambulatory or Major Difficulty in Ambulation	302	Care Giver Illness or Disability	224
At Risk of Being Homeless or Out or Home Placement	125	An application for training center placement has been initiated	5
Current Residence Is Not Satisfactory or Appropriate to Individual's Needs	129	Current Residence Is Satisfactory But Supports Provided are Inadequate	356
Currently Unemployed or No Day Support Options	237	Aging Out of CSA or Foster Care Financing for Residential Services	58
Social Supports Are Limited or Lacking	597	Aging Out of Special Education	181
No Guardian or Legally Authorized Representative	139	Family Has Petitioned to be Relieved of Custody	7

- Social supports were lacking for 22 percent of the individuals on CSB waiting lists. Nine percent were currently unemployed or lacked day support options.
- Fifteen percent were unable to communicate with verbal speech, 14 percent had high or extensive physical or personal care challenges, and 11 percent were non-ambulatory or had major difficulty in ambulation.
- Fourteen percent had aging caregivers and 8 percent were affected by caregiver illness or disability. A small number of families had petitioned to be relieved of custody.
- Thirteen percent resided in a satisfactory setting but lacked adequate supports. The current residence was not satisfactory or appropriate to the needs of 5 percent of the individuals. Five percent were at risk of being homeless or out of home placement. A small number had initiated application for training center placement.
- Almost 12 percent had a co-occurring mental illness diagnosis, 16 percent had a developmental disability other than mental retardation, and 15 percent had a major medical condition or chronic health problem.
- Seven percent were aging out of special education services.
- Five percent had no guardian or legally authorized representative.

CSBs also estimated the number of weeks individuals waited prior to their actual receipt of specific services. Average wait times across the CSBs for specific mental retardation services follow. With the exception of family support and child and adolescent highly intensive services, the average wait times reported for all residential services was longer than one year, with adult

intensive and supervised residential services and child and adolescent supervised residential services exceeding two years.

Average Service Wait Times in Weeks Across CSBs by Service and Population
April 11, 2003

Service	Adult	C&A	Service	Adult	C&A
Initial Assessment					
Initial Assessment	2.93	2.69			
Outpatient Services					
Medication Management	3.76	3.55	Psychiatric Services	4.31	3.91
Behavior Management	9.45	5.36	Case Management	22.48	25.74
Day Support					
Rehabilitation	65.09	31.00	Transitional or Supported Employment	22.53	22.20
Sheltered Employment	37.83	46.17	Alternative Day Support Arrangements	38.13	41.00
Supported Employment Group Model	20.29	34.40			
Residential Services					
Highly Intensive	93.85	33.20	Supportive	101.85	76.62
Intensive	114.78	91.00	Family Support	16.20	14.00
Supervised	110.96	108.00			
Early Intervention Services					
Infant and Toddler Intervention	N/A	5.40			

CSB Substance Abuse Waiting List Information

Numbers of Individuals on CSB Service Waiting Lists by SA Service and Population
April 11, 2003

Service	Adult	Adol.	Service	Adult	Adol.
Outpatient Services					
Psychiatric Services	480	58	Intensive In-Home	0	44
Medication Management	342	58	Methadone Detox	133	3
Counseling and Psychotherapy	1,343	135	Opioid Replacement	229	3
Intensive SA Outpatient	1,102	145	Case Management	819	74
Assertive Community Treatment	49				
Day Support Services					
Day Treatment/Partial Hospitalization	192	0	Supported Employment Group Model	24	0
Rehabilitation	292	5	Transitional or Supported Employment	234	2

Service	Adult	Adol.	Service	Adult	Adol.
Therapeutic Day Treatment	0	42	Alternative Day Support Arrangements	34	0
Sheltered Employment	43				
Residential Services					
Highly Intensive	325	41	Supportive	194	0
Intensive	543	44	Family Support	185	0
Supervised	141	0			
Early Intervention					
Early Intervention	0	1			

Of the 2,997 adults and 287 adolescents on CSB SA waiting lists, a number of individuals were identified by CSBs as having other disabilities, special circumstances or service needs, or specific risk factors. These follow.

Numbers of Individuals on CSB SA Waiting Lists With Other Disabilities, Special Circumstances or Risk Factors: April 11, 2003

Circumstance/Risk Factor	Adult	Adol.	Circumstance/Risk Factor	Adult	Adol.
In Jail, Correctional Facility, Juvenile Detention Center, or Criminal Justice Involvement	1,068	136	Unable to Communicate with Verbal Speech	1	N/A
MI/SA and SA/MI Diagnoses	681	114	Traumatic Brain Injury	27	N/A
MI/MR and MR/MI Diagnoses	14	1	Dementia	1	N/A
MI/MR/SA Diagnoses	15	N/A	High or Extensive Physical or Personal Care Needs	33	N/A
Developmental Disability Other Than MR	18	N/A	Major Medical Condition/ Chronic Health Problem	287	5
Deafness or Hearing Loss	8	N/A	Limited English Proficiency (National Origin)	75	6
Blindness or Visual Impairment	9	N/A	High or Extensive Behavioral Challenges	297	66
Non-ambulatory or Major Difficulty in Ambulation	13	N/A	Has Concurrent Medical Problems, Including HIV/AIDS, TB, or Hepatitis	192	3
At Risk of Being Homeless or Out or Home Placement	803	48	Social Services/Juvenile Just System Involvement	N/A	146
Current Residence Is Not Satisfactory or Appropriate to Individual's Needs	579	35	Current Residence Is Satisfactory But Supports Provided are Inadequate	202	58
Currently Unemployed or No Day Support Options	1,325	N/A	Aging Out of CSA or Foster Care Financing for Residential Services	N/A	1
Social Supports Are Limited or Lacking	1,315	119	Caregiver Is Unable or Unwilling to Provide Support	21	14
Currently Truant, Expelled, Suspended, or School Drop Out	N/A	65	Family Has Petitioned to be Relieved of Custody	N/A	2

Circumstance/Risk Factor	Adult	Adol.	Circumstance/Risk Factor	Adult	Adol.
Aging Care Giver	49	4	Female Who Currently Resides with Dependent Children	232	N/A
Currently Pregnant	28	3	IV Drug Use	229	2

- Social supports were lacking for 44 percent of the adults and 41 percent of the adolescents on CSB waiting lists.
- Of the adults on waiting lists, 44 percent were unemployed or lacked day support options.
- Thirty-six percent of adults and 47 percent of adolescents were in jail, a correctional facility, juvenile justice center, or otherwise in the criminal justice system.
- Twenty-seven percent of adults and 17 percent of adolescents were at risk of homelessness. The current residence was not satisfactory or appropriate to the needs of almost 20 percent of adults and 12 percent of adolescents. Seven percent of adults and 20 percent of adolescents resided in a satisfactory setting but lacked adequate supports.
- Twenty-three percent of adolescents were currently truant, expelled, or suspended or had dropped out of school and 51 percent has social services/juvenile justice system involvement.
- Almost 23 percent of adults and 40 percent of adolescents had a co-occurring mental illness diagnosis and almost 10 percent of adults had a major medical condition or chronic health problem. Almost 8 percent of adults had IV drug use and 6 percent had concurrent medical problems, including HIV/AIDS, TB, or Hepatitis.
- Almost 10 percent of adults and 30 percent of adolescents had high or extensive behavior challenges.
- Almost 8 percent of the adults on waiting lists were women who currently resided with dependent children. Very small numbers of adults and adolescents were currently pregnant.

CSBs also estimated the number of weeks individuals waited prior to their actual receipt of specific services. Average wait times across the CSBs for specific substance abuse services follow. The longest average wait time reported was 13 weeks for supervised residential services.

Average Service Wait Times in Weeks Across CSBs by Service and SA Population
April 11, 2003

Service	Adult	Adol.	Service	Adult	Adol.
Initial Assessment					
Initial Assessment	3.70	2.83			
Outpatient Services					
Medication Management	4.44	4.18	Methadone Detox	3.83	N/A
Psychiatric Services	7.50	5.32	Opiod Replacement	5.00	N/A
Counseling and Psychotherapy	7.12	3.10	Case Management	2.56	2.22
Intensive SA Outpatient	5.68	4.08			
Day Support					
Day Treatment/Partial Hospitalization	3.40	N/A	Supported Employment Group Model	6.00	N/A
Rehabilitation	2.00	2.50	Transitional or Supported Employment	3.67	4.00

Service	Adult	Adol.	Service	Adult	Adol.
Sheltered Employment	8.50	12.00			
Residential Services					
Highly Intensive	4.67	4.33	Supportive	5.00	N/A
Intensive	7.15	12.75	Family Support	N/A	2.50
Supervised	13.00	N/A			
Early Intervention					
Early Intervention	N/A	4.25			

State Facility Discharge Waiting Lists

One area of emphasis in the Olmstead Task Force Report is the elimination of state facility discharge waiting lists. In September 2003, there were 109 patients in state mental health facilities on discharge waiting lists for longer than 30 days because of a variety of extraordinary discharge barriers. Since the Department implemented the Discharge Protocols on January 2, 2001, 348 individuals have been placed on state mental health facility discharge waiting lists. Of these, 239 have been discharged (a discharge rate of 69 percent), with an average waiting period of 144 days. The following table provides information about these 348 individuals, including the number of individuals with specific major discharge barriers, the number discharged, the discharge rate, and the average days waiting prior to discharge.

State Mental Health Facility Discharge Rate by Barrier to Discharge Type
January 2001 Through September 2003

# Patients	Discharge Barrier	# Discharged	Discharge Rate	Average Wait
71 (20%)	Nursing Home	46	65%	203 days
54 (16%)	Behaviors/Provider	44	81%	136 days
64 (18%)	Waiting List – ALF	51	80%	114 days
27 (7%)	Specialized Placement – Funding	20	77%	214 days
26 (7%)	Benefits	16	69%	118 days
26 (7%)	Refuses Discharge Plan	18	69%	139 days
22 (7%)	LAR/Nursing Home	13	59%	240 days
19 (6%)	NGRI	7	37%	178 days
12 (2%)	MR Waiver Placement	7	58%	176 days
8 (2%)	Medical Needs/ Supports	7	88%	84 days
5 (1%)	Out of State Transfer Delayed	2	50%	156 days
2 (1%)	Other Supports	2	100%	170 days
2 (1%)	Out of Catchment Placement	1	50%	91 days
2 (1%)	Legal - Placement	0	0%	--
2 (1%)	Insurance/Benefits	0	0%	--
2 (0%)	Living Accommodations	1	50%	113 days
1 (0%)	INS/Deportation	1	100%	116 days
1 (0%)	Veterans Administration	0	0%	--
348	Total	239	69%	144 days

For the 173 individuals in state training centers who, with their legally authorized representative or family member, have chosen to continue their training and habilitation in the community instead of a training center, the primary mechanism for successful community placements is the Medicaid Home and Community-Based Waiver (MR Waiver) program. Although the number of MR Waiver slots was increased by the 2003 General Assembly, these slots were limited to individuals who are currently in the community. The lack of available MR Waiver slots presents a significant discharge barrier for these individuals.

Implementation of Evidence-Based Practices

Background

Evidence-based practices (EBPs) are those interventions that integrate the best research evidence with the best clinical expertise and patient values. (Sackett, 2000, or Institute of Medicine Report Crossing the Quality Chasm, 2001). Evidence-based practices emphasizing individual participation, choice, recovery, and other individual-centered outcomes have the potential to significantly improve the quality of care for individuals receiving services.

The 1999 Surgeon General's Report on Mental Health prompted increased attention among policy-makers and payers to the issues associated with implementation of evidence-based practices in mental health. The Surgeon General's Report underscored that, for the most part, the effective interventions that exist for many mental disorders are simply not available to the majority persons who could benefit from them.

There are several evidence-based practices for the treatment of serious mental illnesses in adults and serious emotional disturbance in youth. These include:

For adults with serious mental illness:

- Integrated dual disorders treatment
- "New generation" medications
- Medication management
- Assertive community treatment (ACT)
- Illness management and recovery
- Family psychoeducation
- Supported employment

For children and adolescents:

- Multi-systemic therapy
- Family involvement
- Therapeutic foster care
- School programs
- Integrated community treatment
- Some prevention interventions

In the area of substance abuse services, rapid advances in brain-imaging technology, pharmacology and evaluation of counseling techniques and supports have radically altered approaches to treating substance use disorders in the last five years. Scientific evidence overwhelmingly supports addiction and dependence as diseases of the brain. Concurrently, pharmacological approaches to treating substance use disorders have expanded from methadone and LAAM to include buprenorphine and naltrexone for the treatment of opiate addiction and alcoholism, respectively. Currently, the National Institute on Drug Abuse is operating two clinical trial demonstrations in Virginia, both at CSBs. The use of specific counseling techniques, particularly Motivational Interviewing, has been widely studied and shown to be effective in helping persons with substance use disorders address characteristic denial and weak commitment to treatment. Finally, a greater understanding of the prevalence and impact of co-occurring disorders on the development and treatment of substance use disorders is demanding more attention to treatment models for those individuals suffering from both mental illness and substance dependence.

Experts in the field of prevention have developed rigorous approaches to evaluate and identify prevention programs that are effective. These programs are recognized by state and federal

mental health, substance abuse, education and juvenile justice systems as evidence- or science-based programs.

In the area of mental retardation, challenging behaviors can adversely affect an individual's abilities and opportunities to participate fully in any aspect of community life, Positive Behavior Support (PBS) offers a comprehensive, science-based approach to behavior change that teaches people with challenging behaviors, and the people who support them, new skills for successful living in the community. PBS integrates behavioral technology with person-centered values and has been successful with children and adults who have mental retardation or other developmental disabilities and challenging behaviors for more than a decade.

Virginia's Experience With EBPs

Virginia has made significant progress in implementing selected evidence-based practices. For example, Programs of Assertive Community Treatment (PACT) have been developed in 12 CSB areas, and Multi-Systemic Therapy for adolescents is offered at several other CSBs. Most individuals have access to the "new generation" medications, whether in CSB or state facility programs. Outcome data from the PACT initiatives have shown dramatic reductions in state hospital usage, increased stability in living situations for individuals, and reduced involvement with criminal justice agencies. The Department also supports family psycho-education through its contracts with family support groups and the Southwest Virginia Behavioral Health Board. Most individuals receiving services in the public mental health system, however, do not have consistent access to such services.

The Department also funds 12 science-based prevention programs for families, including services for new parents, for Head Start children and their parents, and families with children and adolescents. Program directors are working closely with program developers and university faculty to evaluate the programs. Thus far, program evaluation data indicate that children gained in their awareness of drug harm and increased their levels of cooperation and social skills. Evaluation results for parents show fewer inappropriate parental expectations and increased overall parenting and monitoring skills. Evaluation of the families showed an increase in communication skills and family interaction.

The Department's Office of Substance Abuse Services (OSAS) is undertaking several initiatives to help increase the use of evidence-based practices in CSBs and their contract agencies. First, an extensive program of technology transfer is underway, as described in "Workforce Development" below. In addition, OSAS is developing and distributing Guidance Bulletins to the CSBs that identify "best practices" in specific areas of clinical practice and has started publishing a newsletter via its web page. Further, in collaboration with the Substance Abuse Council of the VACSB, OSAS is developing a manual of core standards that specifically focuses on clinical issues. Finally, OSAS provides regularly scheduled technical support visits to CSBs to assist them in clinical issues, including identifying clinical practice models and assisting with evaluation design.

In the mental retardation field, Virginia state agencies, local service providers, and individuals with mental retardation and their family members received extensive training in the late 1980s and early 1990s from the National Research and Training Center for Positive Behavioral Support at the University of Oregon. This training was replicated around the state in several communities during the mid 1990s. In October 2002, the Partnership for People with Disabilities received a grant from the Virginia Board for People with Disabilities to promote the utilization of PBS across the lifespan of Virginians with disabilities and challenging behaviors. Project goals include obtaining consensus from licensing, certification and funding agencies for PBS utilization for individuals with developmental and other disabilities and the developing a certification process and mechanism for intensive training for PBS practitioners. While this has been a positive initiative, resource constraints continue to limit the availability and consistency of this time-intensive training, and Behavioral Consultation under the MR Waiver is currently

limited to a very small number of providers (approximately 25), few of whom have PBS training. The Department is actively involved in this activity.

Strengthening Evidence-Based Practices for the Future

The Department, CSBs, individuals receiving services and families, and others have recognized the importance of working together to develop, disseminate, and support evidence-based service models and uniform clinical practices that will promote positive individual outcomes. Such efforts would include defining the extent and quality of "evidence" necessary for services and interventions to qualify as evidence-based practices (e.g., multiple randomized clinical trials, quasi-experimental research, qualitative evidence, etc). Adoption of uniform clinical practices by the CSBs would also help promote consistency across services throughout the state and permit clear identification of service system gaps where they exist. While still allowing for local variation and innovation, a core set of evidence-based clinical practices for community services across the state also would help ensure informed individual choices and ease of movement from one service area to another. The Department must increase its focus on adopting evidence-based practices for persons with mental illness, mental retardation and substance use disorders to effectively achieve its mission.

Today, advances in communication technology greatly enhance the dissemination and transfer of information to practitioners and can make the most current research and other information readily accessible to most practitioners, allowing them to integrate this information into their daily practice. Opportunities exist to strengthen Virginia's mental health, mental retardation, and substance abuse services system through this technology.

To effectively adopt evidence-based practices, several ingredients must be in place, including

- Commitment of leadership at each level (state, local, program),
- Education and skill building for practitioners,
- Supportive administrative practices,
- Incentives and rewards,
- Feedback mechanisms (e.g., measurement of outcomes), and
- Stable long-term financial support for EBPs.

Additional resources will be needed to raise awareness of evidence-based practices, enhance competency among providers, and to develop and sustain programs and services.

Access Issues of Individuals with Multiple or Co-Occurring Disabilities

Individuals Who Have Co-Occurring Mental Retardation and Mental Illness

The National Association for the Dually Diagnosed (NADD) has broadly defined dual diagnosis as *the co-existence of the manifestations of both mental retardation and mental illness."* The Report of the Northern Virginia MI/MR Workgroup states that persons with a dual diagnosis can be found at all levels of mental retardation (mild, moderate, severe, profound) and that the full range of psychopathology that exists in the general population also can co-exist in persons who have mental retardation. Estimates of the frequency of dual diagnosis vary widely in the published clinical literature; however, many professionals have adopted the estimate that 20-35 percent of all persons with mental retardation have a psychiatric disorder. The dual diagnosis population has two major sub-groups with very different treatment needs.

- Individuals who typically have a serious mental illness and who function at the mild or moderate level of retardation (MI/MR) – This group most often resides in the community and enters the service system because of challenging, difficult-to-manage behaviors that may pose a threat of serious harm to themselves or others. Some may be at increased risk for admission to a state mental health facility because they require specialized supports in a secure environment.

- Individuals who have severe or profound mental retardation and a serious mental illness (MR/MI) – This group is more likely to be receiving care in an institutional setting, whether in the community or in a state training center.

Both groups require service providers who are knowledgeable and skilled in diagnosis and treatment or habilitation of both mental illness and mental retardation.

Families and individuals receiving services often are not aware that they can have diagnoses of mental retardation and mental illness, and they sometimes fail to recognize the signs and symptoms of mental illness. This lack of awareness increases the likelihood that they will cycle between the mental health and mental retardation service systems and face multiple barriers to accessing the services and supports they need.

Providing appropriate treatment for this population has been recognized as problematic in all states. Virginia does not have a systematic approach for meeting the needs of this population. The current service delivery system is organized by program area (MH, MR, or SA), with staff training and expertise typically limited to one program area. There also is a lack of community-based expertise in diagnosing, treating, and supporting individuals who require specialized assistance. Nevertheless, there are pockets of excellence in every state, including Virginia, which could be replicated.

In July 2002, the Department established a Dual Diagnosis Steering Committee, which is comprised of representatives from CSBs, state psychiatric facilities, state training centers, family members, and private providers. This group is examining the treatment needs of this population and exploring potential strategies for more effectively using current resources and building capacity within the system. Regional teams that mirror the Steering Committee are identifying current service gaps and disseminating knowledge about "best practices" and model programs already in existence. Teams also are identifying alternative funding sources (e.g., start-up or demonstration grants) and developing effective incentive plans for system change.

The Northern Virginia MI/MR Workgroup recently completed a review of cases known by community and state mental health and mental retardation facility professions to have a dual diagnosis. Based on these case reviews, clinical profiles were developed. These profiles were used to identify current services and needed service enhancements that are critical to achieving successful outcomes. These include:

- Formal agreements for collaboration and jointly shared responsibility between mental retardation and mental health services from both the Department and CSBs;
- Collaboration among Department and CSB mental retardation and mental health agencies and private providers of residential and day or vocational services;
- Flexible funding, with immediate availability of funds based on levels of support needed rather than on diagnosis;
- Specialized supervision and well-trained staff that receives specialized training for all personnel at the clinical, medical, managerial and direct services levels in MR/MI issues;
- Accurate psychiatric assessment and diagnoses;
- Interdisciplinary assessment involving staff of both mental retardation and mental health agencies;
- Psychiatrists with previous knowledge of and training in MR/MI issues;
- Intensive case management, with smaller case loads allowing the case manager to take a much more active role in helping the individual develop and maintain everyday life skills and build natural circles of support;
- Sufficient staff resources in both residential and day or vocational locations to allow for one-to-one staffing during crisis and stabilization periods;
- Development of strategies to address crisis situations that are an integral part of an overall treatment or discharge plan;

- Availability of significant behavioral consultation hours and more hands-on care than the typical behavioral consultation;
- Partial hospitalization and crisis stabilization to avoid removing individuals from their homes and as an option to inpatient hospitalization and institution-based care with minimum bureaucracy for the relatively few individuals who need this level of care;
- Specialized outpatient services;
- Program for Assertive Community Treatment (PACT) model specialized in MR/MI issues, and mobile crisis intervention teams of clinical and direct care professionals with expertise in MR/MI issues;
- Suitable day placements to meet individual needs, including vocational and non-vocational options, as well as community college life skills degree programs;
- Community residential placement options and in-home supports with a full range of alternatives (e.g., group homes, specialized foster care, 2-3 bed homes, supervised apartments, mentor roommates, and Life Coaches) and financial incentives for residential private providers to keep beds available when individuals are placed out of the home for short durations during crises;
- Prioritized review of requests and applications for MR Waiver funding for individuals with MR/MI issues;
- Frequent coordination and follow-up by CSB case management staff with residential and vocational placements to ensure adherence to treatment plans and to prevent slippage and crisis episodes; and
- Family and individual education and support groups to recognize dual diagnosis, learn more about treatments, and offer support for dealing with the challenges of a dual diagnosis.

The Northern Virginia MI/MR Workgroup concluded that: "Services should be based upon individual consumer needs and supports rather than disabilities, thus avoiding 'problem shifting' that occurs between MR and MH agencies. Much can be accomplished through collaboration with existing community resources rather than creating new resources in response to present limitations of single MR or MH service sectors."

Individuals Who Have a Co-Occurring Substance Use Disorder and Mental Illness

Co-occurring disorders are an illness characterized by the simultaneous presence of two independent medical disorders – psychiatric disorders and alcohol and other drug use disorders. Co-occurring disorders can occur at any age. Research suggests that as many as half of the adults who have a diagnosable mental disorder will also have a substance use disorder during their lifetime. (Kessler et al. 1994, Regier et al. 1990) Seven to ten million people in the United States have at least one mental disorder in addition to a substance-related disorder. (SAMHSA 2002, Watkins et al. 2001) In 1998, SAMHSA estimated that 7.2 million persons between the ages of 18-54 with co-occurring disorders are living in households. This equates to approximately 191,210 adults in Virginia.

The impact of co-occurring disorders is significant for individuals, families, service providers, and society. Co-occurring disorders are increasingly associated with negative outcomes. (RachBeisel, Scott and Dixon, 1999) Substance use adversely affects the course and outcome of mental disorders for individuals with serious mental illness. Research shows that these individuals are susceptible to poor functioning and clinical outcomes including:

- More severe illness symptoms;
- Increased hospitalization;
- Decreased social functioning and non-compliance with treatment regimes;
- An elevated risk of contracting HIV and hepatitis diseases;
- Greater difficulty gaining access to health services; and

- Increased risk for violent behavior.

A number of studies have shown that co-occurring disorders are associated with increased costs of health services, mainly due to an increase in the use of acute psychiatric services, longer average length of stay in hospitals, and higher hospital admission rates. (AACP, 2000, Leon 1998, Dickey et al. 1996, Bartels et al. 1993, Drake et al. 1991, Lyons and McGovern 1989) Hoff and Rosenheck (1998) investigated the cost of treating substance abuse among patients with and without co-occurring disorders and found that individuals who were dually diagnosed had increased service utilization and cost regardless of which diagnosis was designated as the primary disorder. The public system faces difficult questions in setting appropriate goals and using resources wisely since substance abuse tends to increase expensive service utilization. (RachBeisel, and Dixon, 1999)

In the recent SAMHSA report (2002) to Congress on Co-occurring Disorders, practices resulting in the most positive outcomes for persons with co-occurring disorders included:

- Integrated treatment models;
- Use of integrated assessments;
- Programs of assertive community treatment (PACT);
- Modified therapeutic communities; and
- Motivational interviewing/enhancement to promote engagement in the therapeutic process and enhance positive behavioral change.

Literature supports the notion that an integrated approach to treatment is regarded as most favorable. (RachBeisel, Scott, and Dixon 1999; Drake et al., 2001, Schneider 2000, Drake and Wallach 2000) Integrated treatment, as opposed to sequential or parallel forms of treatment, offers the most positive outcomes for individuals experiencing co-occurring disorders.

The following successful models incorporate evidence-based treatment practices for individuals with co-occurring disorders have been developed and implemented.

- *Motivational interviewing*, either alone or coupled with other techniques such as Cognitive Behavior Therapy and Family Intervention, is effective for treating persons with co-occurring disorders of schizophrenia and substance use. (Graeber et al. 2003, Barrowclough et al. 2001)
- *The New York Model* of treatment is based on symptom multiplicity and severity, rather than on specific diagnoses. In this model, the appropriate service level (consultation, collaboration, integrated services) is matched to the corresponding severity level to improve outcomes. (SAMSHA 2002, NASMHPD and NASADAD, 1998)
- *The Comprehensive, Continuous, Integrated System of Care (CCISC)* is designed to be an accepting umbrella for all best practices in the treatment of individuals with co-occurring disorders. It incorporates the principles of integrated system planning; uniform program capability in dual diagnosis; universal practice guidelines; dual competence; concurrent treatment for simultaneous primary disorders; ease of access; treatment matching to subtypes of dually diagnosed individuals; utilization of parallel phases for treatment planning; readiness stages are not a barrier; treatment over time; and maintaining continuity of relationships with clinicians. (Minkoff, 1989, 1991, 2000, 2001)

Individuals with co-occurring disorders challenge the treatment system. Program barriers for serving persons with co-occurring disorders include a lack of clear service models, administrative guidelines, contractual incentives, and quality assurance procedures and outcome measures needed to implement dual diagnosis services.

The Department's role in addressing this challenge is to ensure that there is a collaborative and integrated response to the needs of individuals with co-occurring disorders. Three major systemic barriers restrict services to persons with co-occurring disorders – restricted services funding, the lack of specifically designed programming, and lack of trained professionals.

Recent budget cuts have forced large state systems to review the effectiveness of programs funded by state and federal funds, measure cost-effectiveness, and ask for increased accountability. The Department's Office of Substance Abuse Services (OSAS) and Office of Mental Health (OMHS) advocate the use of "best practices" and evidence-based practices as part of larger systems change initiatives. This includes the collaborative work of the National Association of State Alcohol and Drug Abuse Directors and the National Association of State Mental Health Program Directors, which uses the New York model of consultation, collaboration and integrated services while recognizing the compatibility of this model with the CCISC model. (Minkoff, 1989, 1991, 2000, 2001)

The OSAS is presently engaged in several activities that address the needs of persons with co-occurring disorders. OSAS has a contractual relationship with Mid-Atlantic Technology Transfer Center to operate the Virginia Institute for Professional Addiction Counselor Training and provide training for substance abuse services professionals throughout the state. Using this contract, OSAS has begun to address co-occurring disorders. OSAS also enhances knowledge acquisition of providers through Guidance Bulletins distributed to all CSBs. Guidance Bulletins offer field guidance regarding regulations and implementation guidelines, evidence-based practices, and upcoming trends.

In addition, OSAS and the Substance Abuse Council of the VACSCB are developing core standards for publicly funded treatment of substance use disorders. These efforts afford an opportunity to incorporate standards related to treatment of persons with co-occurring disorders.

The Department recently submitted an application for a federal grant, State Incentive Grant for the Treatment of Persons with Co-occurring Substance Related and Mental Disorders. The grant proposes to enhance the data infrastructure capacity for Virginia's public substance abuse and mental health system to facilitate reporting of the co-occurring indicator for the Substance Abuse Prevention and Treatment (SAPT) and the Mental Health Performance Partnership Grants. The 3-year grant would involve 11 CSBs; validate instruments for the screening of co-occurring disorders at a pilot site; build capacity of the existing infrastructure by documenting the current workforce; and provide training on evidence-based and culturally competent practices and co-occurring disorders delivered by nationally recognized experts.

Despite these efforts, Virginia does not have a distinctive, planned, comprehensive and coordinated approach to delivering services to individuals with co-occurring disorders. Statutes and regulations governing the use of the Mental Health Performance Partnership Grant include services for dually diagnosed individuals, however these funds constitute only 2 percent of Virginia's allocation to CSBs. There are no mandated guidelines or existing forums that promote minimum acceptable standards for delivery of care for persons with co-occurring disorders and the Department does not currently have a comprehensive approach to training Central Office or CSB staff in the provision of coordinated and integrated services to individuals with co-occurring disorders.

Individuals Who Are Deaf, Hard of Hearing, Late Deafened, or Deafblind

The Department's Advisory Council for Services for People Who Are Deaf, Hard-of-Hearing, Late Deafened, or DeafBlind (Advisory Council), composed of service providers and state agency representatives, is charged with assessing critical needs for this population, providing service oversight, and recommending future direction for service improvements and development in all three disability areas. The Advisory Council has noted that hearing loss affects 8.6 percent of the general population. Between five and ten percent of these individuals also experience a loss of vision. Research generally suggests that the prevalence rates for serious mental illness within the deaf, hard of hearing, late deafened, and deafblind populations are consistent with those found in the general population. Some studies suggest a higher prevalence rate for adjustment and personality disorder, emotional or behavior dysfunction, and substance abuse. Contributing factors to this may include isolation due to communication

barriers, lack of family support, underemployment, late onset of hearing loss and lack of social identification.

Communication barriers associated with hearing loss also prevent access to CSB programs, resulting in the need for specialized and accommodated services for this population. The Department is committed to improving the capacity of the service system to address the communication and cultural access needs of this special population to ensure availability and access to needed specialized resources, professionals, support services, and technical assistance on a regional basis. The Advisory Council has identified the following issues for action during the next three biennia.

- State facilities and CSBs could benefit from additional technical assistance resources to address the communication and cultural needs of this population;
- Regional programs need additional resources to meet the service needs of this population
- Inter-regional collaboration is needed to ensure the continuity of care and the effective provision of mental health, mental retardation and substance abuse services.

Prevention Service Priorities

Substance Abuse Prevention Services

Prevention services include activities that involve people, families, communities, and systems working together to promote their strengths and potentials. Prevention is aimed at substantially reducing the incidence of alcohol, tobacco, and other drug use and abuse, with a focus on the enhancement of protective factors and the reduction of risk factors.

Effective prevention services reduce the number of new cases of substance abuse by reducing risk factors and increasing protective factors. Risk factors may be biological, psychological, social, or environmental and can be present in individuals, families, schools, and the community. Prevention researchers have determined that when a child experiences a higher number of risk factors such as poor school achievement, parents with poor management skills, and neighborhoods where drug use is tolerated, the child is more likely to experiment and use alcohol, tobacco, and other drugs. Protective factors such as social and resistance skills, good family and school bonds, and the capacity to succeed in school and in social activities can reduce the impact of present risk factors. In order to promote greater success and minimize risk for substance use and abuse for children in a community, human service providers, schools, law enforcement organizations, faith and business communities, and parents and youth work together in prevention planning coalitions to create and strengthen protective factors while reducing risk factors in all domains of individuals, homes, schools, and the community.

The OSAS oversees and manages substance abuse prevention services delivered through the 40 CSBs. Currently, all community-based prevention services are funded with the SAPT Performance Partnership Grant and meet federal regulations that direct their use.

The Department adopted a community-based prevention planning process in 1995. Through this process, CSBs work with representatives of human service agencies, education organizations, and local governments to conduct needs and resource assessments, identify service gaps and unserved populations, and plan, implement, and evaluate prevention programs that address the identified risk factors. CSBs reported that prevention planning groups identified the following as the most significant risk factors:

- Availability of drugs,
- Family management problems, and
- Early initiation of problem behavior.

Selection and prioritization of these risk factors is supported by the FY2000 statewide youth survey that found that 28.2 percent of the surveyed youth said alcohol was easy to get and 45.7

percent said cigarettes were easy to get. In the same survey, the average age of first use of tobacco products for Virginia youth was 12.09 years old. The average age of first use for alcohol was 12.62 years old with 16.2 percent of the surveyed youth reporting that they were drinking regularly.

Populations identified as in need of services were school age youth and families. The Prevention and Promotion Advisory Council to the State Board has also identified the need to focus on prevention services for the family.

Interagency Youth Suicide Prevention

The Department works with the Virginia Department of Health, the lead agency for suicide prevention, to promote awareness and provide training to individuals and groups throughout Virginia aimed at reducing suicide across the life span. By May 2003, 60 individuals had been trained to provide Applied Suicide Intervention Skills Training. The Department will continue to provide seminars and promote awareness and education related to suicide prevention using $20,000 allocated for this purpose. The Department also is a member the Interagency Suicide Advisory Committee and the Virginia Suicide Prevention Council. These groups provide advice on planned suicide prevention activities and strategies.

Prevention of Youth Access to Tobacco Products

The Synar Amendment (Section 1926) to the Public Health Service Act requires each state, as a condition of receiving the SAPT block grant, to have in its code and enforce a law that prohibits sale or distribution of tobacco products to youth under the age of 18. In the *Code of Virginia*, this prohibition is clearly stated in §18.2-371.2. States must annually negotiate a rate of allowable noncompliance and demonstrate enforcement by conducting inspections of randomly selected retail outlets to test compliance with the amendment. Failure to achieve the target can result in a penalty of up to 40 percent of a state's SAPT block grant award. Virginia's current negotiated rate is 20 percent, and the state has achieved a rate of 19 percent for this period.

In addition to the penalty, however, there are other consequences of youthful tobacco use:

- One-third of all teenagers who use tobacco will die of tobacco-related disease; and
- Tobacco use among youth is linked to behavioral health problems such as anxiety disorders, depression, and drug abuse.

Several Virginia agencies have distinct programs that focus on youth access issues. The *Code of Virginia* charges the Department of Alcoholic Beverage Control with enforcing prohibition of the sale and distribution of tobacco products to youth (§18.2- 371.2). This agency conducts inspections of retailers for Synar compliance under an interagency agreement with the Department of Mental Health, Mental Retardation and Substance Abuse Services.

The Department entered into an interagency agreement with the Department of Health to take advantage of the expertise in that agency's Office of Tobacco Use Control. This Office has developed community-based coalitions and successful public information campaigns focused on prohibiting youth access. The resulting campaign included window posters, lapel stickers, merchant pamphlets, billboards, and bus signs. Radio public service announcements were developed to stress the importance of the role of parents in preventing tobacco use and to inform them of the risks for physical health and drug abuse linked to smoking. The Department also awarded $400,000 to CSBs ($10,000 each) for the explicit purpose of creating programs that would encourage youth not to smoke and provide assistance in stopping.

The 1999 Session of the General Assembly established the Tobacco Settlement Foundation to "assist in financing efforts to restrict the use of tobacco products by minors through such means as educational and awareness programs on the health effects of tobacco use on minors and

enforcement of laws restricting the distribution of tobacco products of minors" (§32.1-355, *Code of Virginia).*

Goals, Objectives, and Action Steps

Goal 8: Work collaboratively on an ongoing basis with the Secretary of Health and Human Resources (HHR) and all State agencies involved in implementing recommendations in the Olmstead Task Force Report.

Objectives:

1. ***Determine the recommendations in the Olmstead Task Force Report for which the Department will have primary implementation responsibility, those in which the Department will participate, and the manner in which ongoing implementation progress will be measured within the mental health, mental retardation, and substance abuse services system.***

   Action Steps:

   a. Appoint a Department staff member to head implementation efforts and represent the Department on the multi-agency team.
   b. Work with other responsible state agencies to clarify primary and secondary agency implementation responsibilities.
   c. Develop a quality improvement monitoring instrument to track, on an ongoing basis, activities within the mental health, mental retardation, and substance abuse services system related to implementing the recommendations.
   d. Appoint appropriate Department staff members to lead implementation efforts for each recommendation for which the Department will have primary responsibility and those in which the Department will participate.

2. ***Cost out all recommendations in the Report for which the Department has primary responsibility; assist other agencies upon request.***

   Action Steps:

   a. Assemble appropriate Department staff teams.
   b. Identify stakeholders with whom consultation is required.
   c. Using the time frames and recommendations as set forth in the Report, prepare and submit to HHR, DPB and the Governor, cost estimates for implementation of all recommendations for which the Department has primary responsibility.
   d. Provide information upon request to other state agencies having primary responsibility for implementing recommendations.

3. ***Begin implementation of recommendations for which the Department has primary responsibility that do not require legislation or additional funding; assist other agencies upon request.***

   Action Steps:

   a. Assess the recommendations for which the Department has primary responsibility that can be implemented without legislation or funding.
   b. Assemble appropriate Department staff teams.
   c. Identify stakeholders with whom consultation is required.
   d. Using the time frames and recommendations as set forth in the Report and working with all appropriate stakeholders, initiate implementation of each of the recommendations.
   e. Assist other state agencies in their implementation initiatives as appropriate.

4. Prepare legislative proposals and budget requests, as requested by the Governor, for recommendations for which the Department has primary implementation responsibility; assist other agencies upon request.

Action Steps:

a. Assess which recommendations for which the Department has primary responsibility require legislation or funding.

b. Assemble appropriate Department staff teams to develop legislative or budget proposals.

c. Identify stakeholders with whom consultation is required.

d. Using the time frames and recommendations as set forth in the Report, and working with all appropriate stakeholders, prepare the legislative and budget proposals for consideration by HHR, DPB, and the Governor.

e. Assist other state agencies as appropriate in the preparation of legislative and biennium budget proposals for which they have primary responsibility.

Goal 9: Work collaboratively with the Olmstead Oversight Advisory Committee to assure that the Committee is kept apprised of progress in implementing the recommendations in the Task Force Report for which the Department has primary responsibility.

Objectives:

1. Provide support to the activities of the Olmstead Oversight Advisory Committee as needed.

Action Steps:

a. Offer administrative support, within available funding, as requested.

b. Appoint a Department staff member to serve as liaison to the Committee.

2. Use a quality improvement monitoring tool to measure implementation progress.

Action Steps:

a. Develop and test the quality improvement monitoring instrument.

b. Begin using instrument to generate a baseline and quarterly reports, effective January 1, 2004.

3. Make regular reports to the Olmstead Oversight Advisory Committee regarding progress achieved in implementing the recommendations for which the Department has primary responsibility.

Action Steps:

a. Develop reports as requested.

b. Contribute to the annual reports submitted to the Committee.

Goal 10: Provide a statewide safety net of short-term intensive intervention community services for all individuals who experience a crisis due to their mental disability or substance use disorder.

Objectives:

1. Foster development of a full menu of community-based short-term intensive intervention services with statewide accessibility.

Action Steps:

a. Review the various types of community-based short-term intensive intervention services that are being used in other states and examine their effectiveness in reducing those states' reliance upon state facility services.
b. Seek resources to fill existing gaps in the array of community-based intensive intervention services.
c. Continue to work with CSBs, the Virginia Hospital and Healthcare Association, the Supreme Court of Virginia, the Psychiatric Society of Virginia, and the College of Emergency Physicians to identify and resolve issues affecting the delivery of emergency services and acute inpatient care.

Goal 11: Develop a comprehensive array of community-based mental health, mental retardation, and substance addiction and abuse services that promote recovery, rehabilitation, employability, and self-determination and choice.

Objectives:

1. Foster development of a full menu of longer-term mental health, mental retardation and substance addiction and abuse services.

Action Steps:

a. Seek funding to expand community services required by individuals who are on CSB waiting lists.
b. Seek funding to expand community services required by individuals who have been identified as ready for discharge from state mental health facilities and by individuals or their legally authorized representatives who choose to be discharged from state training centers.
c. Work with CSBs, private health care providers, and other provider organizations to develop community service capacity.

Goal 12: Promote and support the implementation of evidence-based practices.

Objectives:

1. Develop shared commitment to adoption of evidence-based practices across Department, CSBs, and state facilities.

Action Steps:

a. Gain Department, state facility, and CSB leadership commitment to adoption of evidence-based practices through meetings with the System Leadership Council and the VACSB MH, MR, and SA Councils.
b. Gain advocacy and other services system partners to support the adoption of EBPs through dialogue with the MH Planning Council, the Governor's Substance Abuse Council, NAMI-VA, MHAV, SAARA, Arc of Virginia, and other organizations.

2. Provide information and technical and evaluation assistance that supports the use of evidence-based practices in publicly funded services for persons with substance use disorders.

Action Steps:

a. Refine design of the Department's Evidence-Based Practices web-site in consultation with CSBs and other users, including consultation with other states.
b. Acquire resources to implement and maintain the Department's Evidence-Based Practices web-site.
c. Continue to provide onsite technical assistance to CSBs to develop, implement, and evaluate evidence-based practices.

d. Continue to work with the SA Council of the VACSB to develop Core Standards based on evidence-based practices.

e. Continue to utilize the OSAS web page (pending implementation of a Department EBP site) and other methods of information dissemination to increase awareness of scientific advances that have implications for the treatment of substance use disorders.

3. Develop approaches to identify, recognize, and reward evidence-based practices, e.g., programs and services that demonstrate positive individual outcomes.

Action Steps:

a. Work with CSBs, state facilities, individuals and families, and private providers representing MH, MR, and SA services to define the nature and quality of research and evaluation "evidence" necessary for demonstrating evidence-based practices vs. exemplary or otherwise promising interventions (e.g. evidence based on multiple randomized clinical trials, quasi-experimental research, qualitative evaluation, expert judgment, etc.)

b. Work with services system partners to develop and implement methods to recognize and reward exemplary programs that demonstrate positive consumer outcomes.

4. Develop one or more "Centers of Excellence" to support development and adoption of evidence-based practices.

Action Steps:

a. Seek funding to develop two regional Centers of Excellence.

b. Explore opportunities with institutions of higher education to collaborate (e.g., through public-academic partnerships) on the development of one or more "Centers of Excellence" to provide information, program and clinical consultation, and training and support to providers who adopt evidence-based practices.

5. Increase Department capacity to apply for and secure grant funds to support adoption of EBPs.

Action Steps:

a. Explore and strengthen partnerships with academic institutions to increase capacity to write grants and acquire grant resources.

6. Increase the number of evidence-based prevention programs for youth and families that address the risk factors of availability of drugs, family management problems, and early alcohol, tobacco, and other drug use.

Action Steps:

a. Provide support and technical assistance in the selection, implementation, and evaluation of evidence-based prevention programs for youth and families.

b. Monitor the provision of evidenced-based prevention programs by CSBs for youth and families through the prevention database.

c. Develop, publish, and distribute the *Directory of Virginia Prevention Researchers and Evaluators*, a resource guide for training and evaluation services in Virginia.

d. Make available evidence-based prevention program materials and evaluation instruments through the prevention database and mail distribution.

e. Support the development and recognition of Virginia prevention programs as model programs.

7. Provide training in evidence-based clinical practices to CSB and state facility physicians and other treatment professionals.

Action Steps:

a. Host a series of training programs and symposia for community and state facility practitioners that feature national experts on the topic of evidence-based practices.
b. Disseminate literature on the benefits and practice of evidence-based medicine to community and state facility medical directors and other clinical practitioners at regularly scheduled meetings.
c. Disseminate available evidence-based practices and clinical guidelines to practitioners in community and state facility programs.
d. Identify area practitioners within the public system and in private practice who already are using evidence-based practices and feature them as speakers at meeting, training programs, and symposia.
e. Establish mechanism for the sharing of information about evidence-based practices between community psychiatrists and facility psychiatrists in the public and private sectors.
f. Develop a training program to address the quality and risk implications of evidence-based practices for the individual practitioner and the organization and larger system.
g. Periodically evaluate the utilization of evidence-based practices in community and state facility programs.

8. Develop the capacity to train, credential, and compensate professionals who can offer Positive Behavioral Support Services.

Action Steps:

a. Complete the activities of the Positive Behavioral Support Services Workgroup.
b. Obtain the agreement of affected agencies, including the Department, to adopt PBS as a "best practice" for people with mental retardation.
c. Establish a credentialing agency with a curriculum approved to certify Behavioral Consultants.
d. Provide training through the Department's Office of Mental Retardation Services to raise awareness about the benefits of PBS in serving individuals with mental retardation.

Goal 13: Improve the quality and appropriateness of support and treatment for persons with a diagnosis of co-occurring mental retardation and mental illness.

Objectives:

1. Provide outreach and education to families and individuals receiving services about dual diagnoses.

Action Steps:

a. Develop educational materials that address various signs and symptoms associated with a person who may have co-occurring diagnoses.
b. Encourage CSBs to assign staff with specific responsibility for helping individuals receiving services and families negotiate the entire set of services that are available to persons with MR/MI issues.
c. Provide opportunities for the families and individuals receiving services to receive education about dual diagnoses and actively participate in treatment planning when an individual is beginning to show signs of decompensation, through the crisis period and during transition back to the community.

2. Promote and reinforce collaboration and joint responsibility in services provision, coordination, and oversight.

Action Steps:

a. Work with the CSBs and state facilities to develop formal memoranda of agreement that specify regional models for service delivery, community-based focus, involvement of all major system partners, specified tasks and responsibilities for all parties, and services based upon individual needs and supports rather than disabilities.

b. Continue to provide administrative support at the state and CSB level for the activities of the MI/MR Steering Committee and the Regional MR/MI Workgroups to document and address issues.

c. Revise current databases or develop a system-wide database to improve the efficacy and usefulness of data collected for individuals with MR/MI, the services and supports they receive and the environment in which the supports are provided, and the manner in which services are reimbursed.

3. Expand specialized community services and supports for individuals with a diagnosis of mental retardation and co-occurring mental illness.

Action Steps:

a. Develop a uniform set of standards for assessment and treatment programs for persons with MR/MI that are based upon levels of support needed and encompass the entire "circle of need."

b. Encourage CSBs to review current case management services and develop a system of intensive case management services that would better address the needs of individuals with MR/MI.

c. Collaborate with the CSBs and state and local housing agencies to explore potential resources to support the development of a fuller range of residential alternatives for individuals with MR/MI.

d. Seek funding to develop a full range of specialized community outpatient services and supports, partial hospitalization, mobile crisis teams, PACT services, and residential and day or vocational services for persons with MR/MI.

e. Seek funding to expand the Northern Virginia Training Center Regional Community Support Clinic model to other training centers.

f. Work with DMAS to review the current waiver consultative model and consider a more direct, hands-on service delivery approach for the behavior specialist working with persons who demonstrate MR/MI issues and establish clinical skills criteria for new behavior consultation contracts for individuals with MR/MI.

g. Establish an approval process for additional behavioral consultants to address the significant resource shortage for service providers and create sufficient expertise in the field.

4. Develop and implement best practice service models in Virginia for persons with a diagnosis of mental retardation and co-occurring mental illness.

Action Steps:

a. Provide joint training for state facility and community administrators, clinicians, and direct care workers aimed at identifying and appropriately responding to the needs of individuals who may have a dual diagnosis, clarifying service responsibilities, and reconciling differences in language, philosophy, and expected outcomes between mental health and mental retardation services providers.

b. Provide technical assistance and training to state facilities and community public and private providers on steps necessary to implement best practices for serving this population.

c. Develop a plan, in collaboration with state facility and public and private community mental health and mental retardation services providers, to implement best practices in community and state facility settings.

5. Provide training for psychiatrists, family practitioners, clinical psychologists, nurse practitioners, physician's assistants, and other clinical staff on psychiatric issues for persons with dual diagnoses of MR and MI.

Action Steps:

a. Arrange for national experts to conduct training sessions for Virginia practitioners.

Goal 14: Provide, through an integrated approach based on evidence-based practices, appropriate assessments, interventions, and specifically designed programming to persons with co-occurring mental illnesses and substance use disorders.

Objectives:

1. Improve the level of consultation, collaboration, and integration among providers of mental health and substance abuse services around policy, funding, staffing, and programming issues.

Action Steps:

a. Establish a committee on co-occurring disorders comprised of Department and CSB mental health and substance abuse staff and MH Planning Council, Substance Abuse Services Council, advocacy group, and other representatives.
b. Provide support to the activities of the committee and necessary workgroups.
c. Work with the committee to produce recommendations for policies, funding, data collection, program development, service delivery, training, and staffing.
d. Work with the committee to make policy, regulatory, and funding recommendations.

2. Enhance the ability of CSBs to provide specifically-designed services for individuals with co-occurring mental illnesses and substance use disorders.

Action Steps:

a. Conduct a major statewide technology transfer activity to promote knowledge and skill among administrators, clinicians, and gatekeepers regarding screening and assessment, case management, program design and treatment planning, funding, and data collection.
b. Establish one "center of excellence" for the treatment of co-occurring disorders that will participate in ongoing evaluation of clinical outcomes and serve as consultants to other providers implementing evidence-based practices for treating persons with co-occurring disorders.

3. Establish uniform diagnostic criteria for identifying persons with co-occurring mental illness and substance use disorders.

Action Steps:

a. Identify or develop uniform diagnostic criteria to identify persons with co-occurring mental illness and substance use disorders and provide ongoing training, consultation, and technical support for effective knowledge transfer.

4. Improve access to housing and case management for persons with co-occurring mental illness and substance use disorders.

Action Steps:

a. Design and implement a pilot integrated service model, including case management, with an evaluation component and provide ongoing training, consultation, and technical support for effective knowledge transfer.
b. Explore use of traditional housing resources and nontraditional resources, such as self-governed residences, for persons recovering from co-occurring disorders.

Goal 15: Ensure quality and continuity of care for people who are deaf, hard of hearing, late deafened, or deafblind and are in need of mental health, mental retardation, and substance abuse services.

Objectives:

1. Address the identified need for additional resources to meet the service demand of the people who are deaf, deafblind, late deafened, or hard of hearing.

Action Steps:

a. Explore and implement strategies to expand statewide services to encompass regions that are currently underserved or not receiving services through the addition of Regional Coordinators and/or Case Managers as dictated by need.
b. Explore with the Advisory Council the need for program enhancements and development of residential services to meet the needs of people who are deaf, deafblind, late deafened, or hard of hearing.

2. Provide resources and interagency collaboration response to meet the needs of individuals who are deaf, hard of hearing, late deafened, or deafblind in receiving mental health, mental retardation and substance abuse services.

Action Steps:

a. Transfer the resource that supported the activities of the State Coordinator's position and the related interpreter reimbursement fund to the regional level in order to enrich local services and enhance inter-regional coordination and collaboration.

3. Strengthen existing policies and guidelines at state facilities and CSBs to promote access for people who are deaf, deafblind, late deafened, or hard of hearing.

Action Steps:

a. Provide technical assistance and guidance on appropriate communication and cultural access to services for people who are deaf, deafblind, late deafened, or hard of hearing.
b. Continue to explore with the Advisory Council ways that that the service system can appropriately refer individuals to culturally competent community and inpatient providers.

Goal 16: Ensure that CSB prevention services address risk and protective factors and service gaps identified by community-based prevention planning coalitions.

Objectives:

1. Continue and strengthen the ability of community-based prevention planning coalitions to engage in an on-going prevention planning process and to select, implement, and evaluate evidenced based prevention programs that address prioritized risk factors.

Action Steps:

a. Increase support for community-based planning for prevention services by collaborating with other federal and state systems and participating in national and state organizations focusing on prevention.

b. Provide risk indicator data through the statewide youth survey, social indicator data bank, and Synar Inspection Report to community-based prevention planning groups for identifying the most salient risk factors and problem adolescent behaviors.
c. Work with the Virginia Tobacco Settlement Foundation to administer a statewide youth survey process.
d. Review annually CSB prevention services plans provided by the Performance-Based Prevention Services data and written reports to ensure that prevention services address prioritized risk factors, are evidence-based, and are supported by collaborative and complementary services of other systems and groups.
e. Provide information and training on methodology and opportunities for collaborative prevention efforts.

2. *Increase opportunities to plan and implement prevention services at the state and local level.*

Action Steps:

a. Share training, technical assistance, and planning resources with a variety of agencies and organizations invested in reducing substance abuse and dependence.
b. Continue to build collaborative relationships at the state level and encourage and support collaboration at the local level to enhance environmental change and implement strategies that reduce exposure to risk and enhance protective factors.

Goal 17: Reduce the incidence and prevalence of suicide among youth and adults in the Commonwealth.

Objectives:

1. Expand suicide prevention training and awareness activities targeted to youth and adults.

Action Steps:

a. Work with the Department of Health and the Department of Aging to develop and implement a state plan for suicide across the lifespan.
b. Provide and support opportunities for training of clinicians, crisis workers and individuals regarding suicide prevention techniques using specialized allocated funds for this purpose.
c. Provide ongoing support of Applied Suicide Intervention Skills trainers with training on updated curricula and training materials.

Goal 18: Continue to reduce youth access to tobacco products.

Objectives:

1. Continue to emphasize reduction of youth access to tobacco products as a legitimate prevention issue related to reduction of drug and alcohol abuse and improved health outcomes.

Action Steps:

a. Continue to educate youth about the harmful effects of tobacco use.
b. Encourage support by the Virginia Tobacco Settlement Foundation of efforts to reduce youth access to tobacco products.
c. Continue to support tobacco specific prevention strategies and activities.
d. Develop a strategic prevention focus on regions reporting highest noncompliance.
e. Continue to measure noncompliance in accord with the Synar Amendment.

Addressing State Facility Needs in a Restructured System of Care

State Facility Staffing Requirements

The Department must ensure that each state mental health and mental retardation facility has sufficient numbers of trained personnel across the entire spectrum of clinical and direct care positions to provide quality care and treatment. Sufficient staffing is absolutely necessary in order to provide appropriate client assessment, treatment, rehabilitation, training, and habilitation in accordance with clinical standards; and create and maintain a safe treatment environment.

The Civil Rights of Institutionalized Persons Act (CRIPA) established broad authority for the United States Department of Justice (DOJ) to investigate matters of infringement on the constitutional rights of patients cared for in state facilities. From May 1990 until August 2003, the U.S. Department of Justice (DOJ) investigated conditions at four state psychiatric facilities, Eastern State Hospital (ESH), Central State Hospital (CSH), Western State Hospital (WSH) and Northern Virginia Mental Health Institute (NVMHI), and at the Northern Virginia Training Center (NVTC). Site visits by DOJ at these facilities determined that they were out of compliance with the Civil Rights of Institutionalized Persons Act (CRIPA). Specifically, the facilities were found to be significantly deficient in providing constitutionally adequate, appropriate psychiatric assessment and treatment as well as adequate medical care. A core problem at each facility was inadequate levels of trained, qualified staff necessary to provide the services needed by their individuals.

As a result of findings from several site visits, the Commonwealth entered into agreements with the DOJ that required Virginia to bring each of these facilities into compliance with certain staffing levels believed to be necessary to render constitutionally adequate mental health care. During the litigation by the U.S. Department of Justice, the General Assembly appropriated funding to create additional staff positions and implement other improvements at the five state facilities under DOJ investigation. The Commonwealth has been successful in meeting the requirements in each facility's settlement agreement, with four of the agreements filed with the federal court; and the fifth recently closed by correspondence from DOJ.

The DOJ settlement agreements place an obligation upon the Commonwealth to provide adequate levels of treatment at state facilities by trained, qualified staff. Although the Department has made significant strides in improving state facility staffing levels, there still are areas where the level of care does not meet the levels set forth in the DOJ settlement agreements. It is the Department's goal to resolve staffing inequities among the facilities, and thereby improve the quality of services statewide.

Several state facilities have been able to increase their staffing ratios somewhat by reducing beds as community initiatives such as the Discharge Assistance Project (DAP), Programs for Assertive Community Treatment (PACT), the Region IV Acute Care Pilot Project, and Medicaid Mental Retardation Home and Community-Based Waiver were implemented. However, such strategies have been hindered by the state budget crisis of the past two years, which required state facilities and CSBs to reduce their operating budgets.

The most serious staff shortages exist at four training centers: Central Virginia Training Center (CVTC), Southeastern Virginia Training Center (SEVTC), Southside Virginia Training Center (SVTC), and Southwestern Virginia Training Center (SWVTC). Two of these facilities are very large congregate settings. These training centers primarily serve individuals who function at severe and profound levels of mental retardation. These individuals are the most vulnerable of all Virginians served in the state facilities. A large proportion of these individuals is non-ambulatory (requiring specialized wheelchairs) or needs significant staff assistance to walk. Many have multiple, complex medical conditions such as seizures, scoliosis, gastro-intestinal problems, hearing and/or visual deficits or loss, and speech impairments. These medical needs

are projected to increase in the years to come because the training center population is aging. All of the conditions make appropriate staffing critical to the well being of these individuals.

Specific staffing issues at the training centers include, but are not limited to nurses and direct care staff; psychiatrists (for those who are dually diagnosed), primary care physicians, psychologists (Ph.D./behaviorist), primary care physicians, dieticians, and occupational and physical therapists. To meet the physical needs of their residents, the training centers also need additional rehabilitation engineers (for specialized wheelchairs), speech pathologists, and audiologists. The level of need, however, varies across these facilities.

In addition, all training centers are experiencing greater demands to serve persons who have mild or moderate mental retardation but also have challenging behaviors that require significant behavioral interventions. In order to meet those needs and to provide community consultations to divert potential admissions, the training centers need to establish Behavioral Management Teams, which require smaller caseloads and additional psychologists.

The state mental health facilities with significant staffing issues are Southern Virginia Mental Health Institute (SVMHI), Southwestern Virginia Mental Health Institute (SWVMHI), and the Commonwealth Center for Children and Adolescents (CCCA). Although improved staff-to-patient ratios were achieved in recent years by census reductions, none of these facilities has staffing ratios that meet the levels agreed upon in the DOJ settlement agreements. These facilities treat individuals with multiple, complex psychiatric, medical, and psychosocial problems. Improved clinical staffing is essential to provide appropriate care. The clinical and direct care staffing needs vary across these facilities. Given the current small size of state facilities and the limited availability of community-based alternatives, additional bed reductions at these facilities are not appropriate at this time.

All state facilities are experiencing increased pharmacy costs as well as increases in gas and fuel costs for which funds are not currently budgeted. Several facilities also have equipment and van replacement needs. Additional support staff positions also are needed at these facilities to 'free up' clinical and direct care staff to focus on client treatment and habilitation. In a time of nursing shortages, such tasks are not only a waste of an essential clinical resource but also negatively impact recruitment and retention.

SVP Program Implementation

The enactment of legislation creating a civil commitment program for sexually violent predators (SVP) has provided the Department with a set of new challenges and responsibilities. The definition of sexually violent predator in §37.1-70.1 means any person who (1) has been convicted of a sexually violent offence or has been charged with a sexually violent offense and is unrestorably incompetent to stand trial pursuant to §19.2-169.3 and (2) because of a mental abnormality or personality disorder, finds it difficult to control his predatory behavior which makes him likely to engage in sexually violent acts. The civil commitment program outlines a number of steps in the civil commitment process, including:

- The Department of Corrections (DOC) director identifies inmates convicted of a predicate crime who are between 10 and 6 months from their release date and who have met the level of risk required for civil commitment to the SVP program;
- The Commitment Review Committee (CRC), on which the Department sits, screens and documents predicate crimes, assigns cases for assessment, and makes referrals for an in-person mental health examination by a licensed psychiatrist or licensed clinical psychologist designated by the Department for diagnosis and documentation of a mental abnormality or personality disorder;
- The Office of the Attorney General reviews the case and petitions for civil commitment of the inmate with the Circuit Court where the inmate was last convicted for a predicate crime or notifies the DOC and Department that a petition will not be filed;

- The Circuit Court schedules a probable cause hearing to determine whether probable cause exists and orders, if the judge finds that probable cause exists, the inmate to remain in secure custody until a commitment hearing is conducted;
- The Circuit Court conducts a trial (bench or jury) to civilly commit the inmate as a sexually violent predator and rules that:
  - The inmate is not civilly committed or is conditionally released, or
  - The inmate is civilly committed and the court sets conditions of commitment; and
- The inmate is civilly committed as a sexually violent predator and is placed in the custody of the Department for control, care, and treatment.

The Department has established a new behavioral rehabilitation facility (SVP program) to provide treatment services to sexually violent predators who are civilly committed to the Department at the end of their confinement in a DOC facility. The SVP program will provide individualized treatment in a secure environment. International experience with this population demonstrates that a rehabilitation approach that uses cognitive-behavioral principles focused on relapse prevention is the most effective. Treatment will involve multiple, daily group sessions, individual behavioral therapy, vocational training, and work therapy and programs, as appropriate. Direct care staff will work with clinicians to create an environment that challenges deviant and criminal thinking and behavior while reinforcing appropriate behavior. Efforts are underway to hire the staff needed to implement the treatment program operations and provide necessary security when the first individuals are committed to the program for treatment.

The SVP program is housed on the North Campus of the Petersburg campus, where two vacant buildings have been retrofitted to accommodate the treatment and security needs presented by this group of individuals. These vacant buildings were selected because they have been well maintained and were the most feasible for renovation in a timely manner and within the available budget. The first building will be ready for occupancy upon commitment of the first individuals, which is likely to occur in October 2003. The Department projects that the census for the SVP program will be 27 by June 1, 2004.

The Petersburg campus facility is not adequate to house the program on a permanent basis. Although manageable for the short term, it has inadequate treatment and program space, offers less freedom to residents than they had in prison, and has high staffing costs. The lack of program space and freedom of movement are constitutional issues and may be actionable. A commitment has been made to the Petersburg and Dinwiddie community to find a permanent site for this program elsewhere.

The Department has conducted two site location studies for the SVP program. In early 1999, HB1775, SB845, and SJR 334 required that Department and the DOC conduct a study of the SVP assessment center and treatment program. This study was completed in December 1999. A second study was directed by Item No. 331.C3 of Chapter 899, 2002 Acts of the Assembly. This second study refined and extended the first study, and was completed in December 2002. Both studies recommended the construction of a new facility at a site proximate to both a correctional and mental health facility.

The Department assembled a study team that included representatives from DOC and consultants with expertise in architecture, engineering, human resources, facility operations and sexually violent predators. Site selection criteria included reasonable distance to a major university with a forensic psychology program; proximity to a DOC facility for emergency support; proximity to a Department facility for operational support; recruitment potential and labor force; community acceptance; political support; centrality for family access; and proximity to an urban area. All Department and DOC properties were evaluated as well as a Juvenile Justice Facility. Consideration was given to both new construction and renovation of an existing facility.

Construction of a new facility was determined to be the most efficient to staff and operate and provide the safest and most effective program. It was further determined that, should the Commonwealth finance the new facility under the Public Private Educational and Infrastructure Act of 2002 (PPEA), the cost of the "mortgage" was less than the differential staffing cost of adapting and operating an existing or renovated existing facility. This results from having a purpose-designed facility that maximizes staff efficiency through building layout. For instance, by improving sight lines, the number of interior security staff can be reduced, without a reduction in safety and security. Capital costs for construction of a new facility, estimated at $43.6 million, have been incorporated into the Department's Capital Budget Proposal.

Over the next fiscal year and thereafter, additional planning will be needed to determine anticipated rates of admission, make a final determination regarding the program site, and secure adequate funding levels from the General Assembly. The Department assumes that the number of individuals civilly committed to the SVP program will gradually increase and staff recruitment will be phased in during FY 2004. The Department will closely monitor the operating budget and will revise projected budget requirements for FY 2004 and FY 2005 as necessary.

State Facility Infrastructure Requirements

Even with current restructuring efforts to create a truly community-based services system, state mental health and mental retardation facilities will continue to be essential components of Virginia's publicly funded services system. As such, the Department must ensure that its state facilities are safe, efficient, well maintained, and appropriately designed to meet the needs of patients and residents receiving services.

As an immediate priority, the Department must bring existing state facility living areas up to current life safety standards. Many currently occupied buildings are not appropriate for the types of individuals who now need state facility services. Some buildings lack the accessibility appropriate for the level of physical disabilities experienced by persons now receiving facility services. Other buildings lack current fire detection systems and other early detection safety systems. The shift to community care provides opportunities to reevaluate the current use of state facility assets, including real estate, buildings, furnishings, and power generation, and to consider options such as:

- Closing wards and cottages as the census of state facilities decreases,
- Using furnishings from closed units and cottages to improve the living areas in other facilities or in CSB managed short- term residential stabilization or transitional services provided on state facility grounds, and
- Leasing state facility real estate to CSBs to expand local service arrays.

The Department's 2004-2006 capital program submission will have three major components.

- Continued repair or replacement of failing infrastructure, including breaking water mains, collapsing sewers, and leaking steam and hot water distribution systems;
- Construction of an appropriately designed facility to permanently house the Sexually Violent Predator (SVP) program; and
- Systematic replacement of aging state mental health and mental retardation facilities.

Over the past decade, the census of most state facilities has dropped. State facility campuses encompass more than 375 buildings and 6.3 million square feet – 19 percent of which are vacant. State facility programs and client profiles also have changed dramatically. A commensurate change in state facility physical plants has not occurred. The Department continues to occupy buildings that range in age from 6 to over 100 years old. The average age of state facility buildings is more than 43 years old. Consequently, many of these buildings are inefficient to operate and are inappropriate for their current patient populations.

The Department's capital program will recommend the systematic replacement of existing large, campus style facilities with more efficient and appropriately sized facilities. Several large mental health facilities, now comprised of numerous buildings and sprawling campuses, would be replaced with facilities housed in single buildings, using an institute model of approximately 200 beds. Similarly, the Department will recommend that the large mental retardation facilities be replaced with buildings designed to better serve their more medically acute and fragile residents. The Department also will propose that Western State Hospital and Eastern State Hospital (excluding the Hancock Center) be replaced in the 2004-2006 biennium. Other large, underutilized or inappropriately designed facilities would be addressed in subsequent biennia.

Goals, Objectives, and Action Steps

Goal 19: Assure that state mental health and mental retardation facilities provide quality assessment, treatment, rehabilitation, training, and habilitation services that are appropriate to the needs of individual patients and residents.

Objectives:

1. Bring all state mental health and mental retardation facilities up to and maintain the active treatment and staffing levels provided in the Department's settlement agreements with the U.S. Department of Justice under the Civil Rights of Institutionalized Persons Act (CRIPA).

Action Steps:

a. Maintain compliance with provisions of the former DOJ settlement agreements at NVTC, ESH, NVMHI, CSH, and WSH.

b. Seek funding to increase staffing levels at the CVTC, SEVTC, SVTC, and SWVTC to bring them closer to compliance with DOJ expectations at the NVTC.

c. Seek funding to address staffing issues at the SVMHI, SWVMHI, and CCCA.

d. Seek funding to address increased pharmacy costs, equipment and van replacement needs, and increases in gas and fuel costs for which funds are not currently budgeted.

e. Support the efforts of the Office of the Inspector General to monitor the progress of state facilities in improving quality of care.

Goal 20: Provide individualized treatment services in a secure environment to individuals civilly committed to the Department as sexually violent predators.

Objectives:

1. Open and operate a maximum-security mental health facility for up to 72 individuals.

Action Steps:

a. Seek funding to fully staff and operate the new SVP program.

b. Recruit and train necessary clinical, security, and administrative support staff.

c. Continue to work with the advisory council comprised of representatives of local government, local legislators, local public safety agencies, and concerned citizens to identify and resolve community concerns.

2. Provide an environment of care for each SVP program resident that is safe for residents and staff and consistent with Departmental Human Rights regulations.

Action Steps:

a. Use security consultants from DOC, the Department's Human Rights Office, and other states' SVP programs to inform security design and staffing.

b. Eliminate blind spots through design, adaptation, security protocols, and the use of staff and camera placement.
c. Provide an environment of care that is consistent with Departmental Human Rights regulations.

3. Provide each resident with access to meaningful sex offender-specific treatment.

Action Steps:

a. Use nationally recognized SVP treatment experts to inform the development of treatment program protocols and practices so that they are consistent with other states' SVP programs.
b. Provide treatment methods and modalities in times and frequencies consistent with Departmental clinical Departmental Instructions.
c. Provide each resident with access to group and individual therapy as appropriate.

4. Provide each resident with access to psychosocial rehabilitation and work activity.

Action Steps:

a. Use national guidelines for rehabilitation, work, and recreation activities to inform program policies, procedures, and activity plans.
b. Use Departmental psychosocial rehabilitation experts to assist in the design and development of appropriate work and recreation activities.

5. Offer each resident the maximum opportunity to develop the self-control necessary for returning to his communities.

Action Steps:

a. Provide each resident with access to therapeutic methods designed to reduce interest in abusive sexual themes.
b. Provide each resident with access to therapeutic methods designed to reduce impulsive sexual response to abuse sexual themes.
c. Provide each resident with access to therapeutic methods designed to increase knowledge of, interest in, and sexual attraction to appropriate sexual themes.

6. Construct a new Center for Behavioral Rehabilitation in a permanent location.

Action Steps:

a. Identify an appropriate location close to major universities and with a suitable employment pool.
b. Develop community support for placing the facility in this location.
c. Secure legislative support for the design and construction of a permanent SVP facility.
d. Secure sufficient funding to implement facility design and construction.

Goal 21: Assure that the capital infrastructure of state mental health and mental retardation facilities is safe, appropriate for the provision of current service methods, and efficient to operate.

Objectives:

1. Improve the capital infrastructure of state mental health and mental retardation facilities to assure their compliance with life safety and applicable building codes and their appropriateness for active treatment and habilitation services.

Action Steps:

a. Seek funding to address individual state facility capital outlay needs identified in the Department's Six Year Capital Outlay plan.

b. Continue to update individual state facility master plans to respond to the programming needs of patients and residents.

Assuring Service Quality, Effectiveness, and Responsiveness in a Restructured System of Care

As Virginia's system of public mental health, mental retardation, and substance abuse services is restructured, the Department must take affirmative steps to ensure that individuals being served receive quality services that are effective and appropriate for their individual needs. One of the primary responsibilities of the Department is to assure and continually improve the quality, effectiveness, and responsiveness of community and state facility services. To achieve this, the Department emphasizes a variety of quality improvement and oversight activities, including protecting the human rights of individuals receiving services in state facilities and community programs, defining and supporting the implementation of clinical best practices, establishing uniform clinical and administrative guidelines, licensing services providers and locations, and monitoring the quality and performance of community and state facility services.

Promotion and Oversight of Quality Care in Community Programs and State Facilities

Licensing Services Providers and Locations

By Code, the Department's Office of Licensing is required to license providers that offer services to individuals with mental illness, mental retardation or substance use disorders, and three developmental disabilities services. It is also required by Code to conduct annual unannounced inspections and investigate all complaints in all licensed services.

The provider and services caseloads of Department licensing specialists grow each year. During calendar year 2002 alone, the caseload grew 21 percent due to:

- Normal increases in the numbers of new providers, services, and locations; and
- New requirements to license additional providers, including 31 Assisted Living Facilities that were required to convert to the Department's licensing, over 40 case management services, and services under the Individuals and Families Developmental Disabilities Waiver.

The number of new applications received to date this year represents the equivalent of another half caseload. As of June 30, 2003, there were 38 new provider applications and 51 new service applications. This additional caseload has been absorbed with no new staff resources. While the Department has instituted numerous efficiencies to meet growing demands, staff are working overtime consistently to keep up with the workload, creating serious questions concerning how much longer the basic statutory licensing requirements can be met.

Future demands are almost certain to overwhelm the ability of the Department to appropriately oversee quality of care in community programs:

- *Restructuring/Reinvestment* – As the Commonwealth transfers more care to the community through reinvestment and restructuring projects, there will be an even greater increase in providers and services that must be licensed. Adequate oversight of these services to assure safety and an acceptable level of care and treatment for individuals served will be critical to the success of these initiatives. Experiences in other states and jurisdictions reveal that, when institutional services have been converted to the community and adequate oversight is not provided, serious problems related to health and safety can occur. These issues have arisen in Washington, D.C., Georgia, New York, Connecticut, and Ohio, which experienced unacceptable levels of abuse, deaths, and injuries to individuals in community programs. Lack of oversight and funding were cited as reasons for these conditions.

- *Children's Services* – In the last calendar year, licensed children's residential services grew 39 percent.
  - The 2003 General Assembly required DMAS to develop a system of Medicaid funding for community-based residential care, which will be a step-down service from psychiatric residential treatment. Current proposals provide that group homes licensed by the Department, which offer a higher level of service, would be reimbursed at a higher rate than other licensed group homes. Ordinarily, new providers apply to be licensed as children's residential treatment providers at a greater rate than other services and this funding will be an added incentive. Caseloads are expected to continue to rise as a result of this initiative.
  - The Department was recently notified that the Department of Education intends to transfer licensing responsibility for 22 residential children's group home programs the Department without any transfer of resources.
- *Brian Injury Services* – Legislation is being proposed to authorize the Department to license Brain Injury Programs under the proposed Brain Injury Waiver.
- *MR Waiver Slots* – When the General Assembly increases the number of Medicaid Mental Retardation Waiver slots, as it did in 2003, there is a resulting increase in new provider applications to provide waiver services.

The Department cannot maintain its statutory requirements for licensing oversight with growing caseloads and no new staff resources. At least two new licensing specialist positions are needed to manage current caseloads and address projected future growth in caseloads and increased oversight requirements associated with new community Medicaid MR waiver beds. The Department has 12 inspectors licensing, conducting annual inspections, and investigating complaints in 1,032 services (1:86 ratio) at 2,471 (1:206 ratio) locations. These caseloads are believed to be significantly higher than licensing caseloads in other agencies.

One approach to mitigating against the need for an even larger number of licensing specialists would be to adopt a risk-based system of licensing. This would be accomplished by removing the statutory requirement for annual unannounced inspections for non-residential services such as day support, outpatient, intensive in-home and partial hospitalization that maintain a record of substantial compliance. Instead, unannounced inspections would occur at least biennially for these services. Unannounced annual inspections would still be required for all residential and inpatient services and for other services that have a record of non-compliance.

In relation to developing a risk-based system, the Department is planning to analyze incidents, deaths, and citations to more systematically triage its efforts. The goal of this effort is to categorize risk areas and identify expected responses by staff depending upon the level of risk.

The Department also is considering legislation to clarify that contractors of licensed facilities are required to obtain criminal history background checks of all direct care employees and legislation that would improve the ability of the Department to more quickly act to protect individuals whose life, safety or health is in jeopardy.

Protection of Individual Human Rights

The *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services* (12 VAC 35-115-10 et seq.) became effective on November 21, 2001. These regulations replaced the three sets of human rights regulations for the state facilities, community programs, and licensed private psychiatric hospitals that had been in effect for many years. These regulations explain and expand upon the fundamental rights of individuals receiving mental health, mental retardation, and substance abuse services as described in § 37.1-84.1 of the *Code of Virginia*. The regulations recognize that individuals receiving services have a right to full participation in decision-making, and clinically appropriate treatment. These regulations also define the

composition, role, and functions of the Department's human rights system, including Local Human Rights Committees (LHRCs) and the State Human Rights Committee (SHRC). They establish time frames and clear procedures for resolving individual complaints.

The Department's Office of Human Rights (OHR) makes advocacy services available in accordance with Va. Code §37.1-84.1 and 12 VAC 35-115, et seq., to approximately 190,000 individuals receiving services from the state facilities operated by the Department, all services licensed by the Department, and all services funded by the Department. The OHR assisted with, and/or monitored the investigations of, 1,780 allegations of abuse and neglect and 1,846 human rights complaints in 2002. Additionally, the OHR monitors all providers for compliance with 12 VAC 35-115, et seq., and provides consultation, training, and assistance to over 400 volunteer members of the 65 LHRCs.

The Department's human rights advocacy system is currently operating well beyond its capacity, as noted in the study completed in response to Item # 323 of the FY 2000 Appropriation Act. The study, published as House Document No. 21, recommended that 10 additional positions be added to the OHR in order to adequately provide advocacy services in accordance with 12 VAC 35-115, et. seq. The Department has not been able to implement these recommendations, and two advocate positions, the OHR Assistant Director, and two secretaries have been abolished due to budget reductions in 2001 and 2002.

Restructuring and reinvestment of the services system, the implementation of the new SVP program, and the licensing of additional providers will increase the OHR workload in the following areas:

- The intensity of advocacy services to individuals and families who are affected by changes in the service delivery system will likely increase as individuals and family members experience such changes;
- Consultation to and monitoring of human rights protections in new service providers;
- Current LHRCs are at capacity across the state, and the addition of any service providers will result in the need for recruitment, development, and training of new human rights committees; and
- Investigations of allegations of abuse and neglect and human rights complaints are likely to increase due to increased numbers of new providers and services.

Compliance with State Facility Active Treatment and Habilitation Clinical Care Expectations

To address findings of DOJ investigations under CRIPA, the Northern Virginia Training Center, Eastern State Hospital, Northern Virginia Mental Health Institute, Central State Hospital, and Western State Hospital established plans to address improvements in the care and treatment of their patients and residents. Key requirements for DOJ approval of these continuous improvement plans included:

- Increased staff-to-patient ratios;
- Enhanced staff training;
- Enhanced structure and provision for medical care;
- Increased individualized active treatment with patient involvement in treatment planning;
- Structured and coordinated planning for discharge and placement in the most integrated setting; and
- Focused efforts to protect patient and resident rights, safety, and well being, especially related to the use of seclusion and restraint.

By 2003, all of the involved facilities had successfully implemented their continuous improvement plans and their DOJ lawsuits were dismissed with prejudice. The Department's

Office of Facility Operations/Quality Assurance continues to play a role in assuring that the facility plans of continuous improvement are successfully implemented and maintained.

In 2001, the Department's DOJ consultant was contracted to review the four mental retardation training centers that had not been reviewed by DOJ (CVTC, SEVTC, SVTC, and SWVTC) with specific focus on: mental retardation diagnosis and resident level of functioning; psychiatric consultations, medications, and polypharmacy for residents with dual diagnoses; medical care and treatment; use of restraints and locked time out; and adherence to the Department's administrative policies relating to risk management, abuse investigations, and quality improvement. As a result of these reviews, the training centers prepared plans of improvement related to specific findings. The Department continues to seek resources to bring staffing for each of these facilities closer to compliance with DOJ expectations.

The Department also works with the state facilities to address and monitor facility-specific plans of improvement based on a variety of findings by external consultants, the Department's Internal Audit Office, and the Office of the Inspector General (OIG). Created by legislation in 1999, the OIG's primary mission is to challenge Virginia's public mental health, mental retardation, and substance abuse services system to provide quality services that are consistent with contemporary clinical guidelines and financial management strategies. The OIG acts upon its mission through on-site inspections of the state facilities. These inspections may result in recommendations to the Department and the individual state facilities to correct identified problems or deficiencies. The OIG is also responsible for keeping the Governor and the General Assembly fully informed of significant concerns, recommendations for corrective actions, and progress made in the implementing these actions.

The OIG has three standardized inspection formats, one of which acts as the basis for each site visit. These formats follow.

- *Primary Inspections* - These are routine, unannounced comprehensive visits typically lasting several days. Their purpose is to evaluate all components of the quality of care delivered by the state facility and to make recommendations regarding performance improvement.
- *Secondary Inspections* - These are performed secondary to the identification of a potentially serious problem that may either represent a pattern of substandard care or may have a direct, immediate effect on patient health, safety, or welfare. Their purpose is to evaluate any potential problems and to make recommendations for performance improvement. These inspections may be announced or unannounced.
- *Snapshot Inspections* - These are brief inspections that are always unannounced and occur after regular work hours and on weekends. Their purpose is to review patient activities, staff coverage, and general building conditions. These inspections may serve as a means to follow-up on issues of particular concern at a particular facility.

During primary inspections, there are eight categories that are generally reviewed relative to quality of care. These are: treatment of patients with dignity and respect, use of seclusion and restraint, active treatment planning, access to acute medical care, the treatment and residential milieu, relationship of the facility with academic institutions, special facility issues, and risk management and quality assurance initiatives. In addition to these inspections, the OIG has completed several overarching reports on a variety of topics ranging from discharge studies to access to acute care for children. These reports have been useful in focusing attention on areas of need in the Commonwealth's mental healthcare delivery system.

A primary responsibility of the Department's Office of Quality Improvement is to identify systemic areas where additional policy guidance is required. This Office serves as the Department's liaison to the OIG relative to investigations findings regarding state facilities. Office staff and individual state facilities collaborate in responding to concerns raised by the Inspector General. The Office works with each state facility to develop appropriate time frames

and outcome measures for inclusion in their plans of correction. Implementation of these plans is then internally monitored.

Adherence to State Facility Clinical Guidelines

In FY 1999, the Department developed consistent and uniform clinical guidelines and operating procedures in areas such as state facility admissions and discharges, active treatment planning, medical assessment, medication management, medical emergency response systems, emergency use of seclusion and restraints, abuse and neglect prevention, and competency-based staff training and development. These guidelines were based upon a system wide review of state facility procedures and operations that affect the quality of care. Most of these procedures have been implemented by the state facilities. These guidelines are not intended to replace clinical judgment. Rather, they would promote and support clinical practice.

Development of uniform clinical guidelines and operating procedures continues to be based on and guided by the clinical skills and experience of facility professionals and expert consultants, the best currently available clinical evidence, the experiences of other public and private service agencies, and state and federal regulatory and certification requirements. This year, the Department developed a policies and procedures manual to implement the privacy rule under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA). A key aspect of this improvement effort involves monitoring the performance and effectiveness of new clinical guidelines and operating procedures to assess whether:

- The new processes produce the desired result;
- The processes require redesign; or
- There are opportunities to further improve the new guidelines and procedures.

Performance data, reflecting a wide range of clinical and operational activities, are being collected through a Data Dashboard, the Seclusion and Restraint Database, the QS1 Pharmacy Database, Annual Facility Quality Management Reports, and the MedIs Medication Reporting System, all of which are used to identify service delivery trends and determine the need for new clinical guidelines and operating procedures. Ongoing evaluation of the effectiveness of uniform operating procedures and clinical processes will occur as a cooperative effort between the Department's Central Office and state facility quality managers, health information managers, training directors, and other facility personnel responsible for collecting or tracking clinical and regulatory data.

Quality Management Review Activities in State Facilities

The Department has developed a central Clinical Services Quality Management Committee (CSQMC) that reviews the appropriateness, effectiveness, and overall quality of care in state facilities. This review is an important tool that allows the Department's leadership to continuously evaluate and improve the quality of patient care through individual case reviews, the assessment of physician practice patterns, and the evaluation of systems and processes that support medical and clinical practice.

Peer review is a privilege afforded physicians under the *Health Care Quality Improvement Act of 1986* and by state laws governing peer review activities. It is critical that such a privilege be guided by a set of clear rules and requirements. To this end, the Department has developed policies and procedures to formalize the Department's quality management processes; to protect the confidentiality of patients and physicians; to ensure the appropriate use of peer review information; and to distinguish this review from other administrative and operational review mechanisms.

Utilization Management Infrastructure

Currently, different methods of utilization management (UM) are used by each state mental health facility and CSB. Different UM methods also are employed by hospitals and other healthcare providers that contract with CSBs or the Department for local inpatient hospitalization and crisis stabilization services. Utilization management in this context refers to those methods used to conduct a review of the need (utilization review) and the best use of available mental health resources (utilization management) before or during a period of service.

This variety of service settings and the multiple service programs compound the difficulty in aggregating and comparing service use patterns. Implementing a utilization management infrastructure at the system level would focus on:

- Establishing clinical criteria compatible with the specific service level;
- Collecting these data and clinical profile data in a consistent manner
- Communicating these data to the interested services providers, such as regional partnership planning groups, regional investment projects, CSBs, state facilities, and inpatient bed purchase contractors; and
- Collecting data in clinical profiles for use in describing the characteristics of special needs populations.

These data could then be used and managed by the state facilities, CSBs, and in some instances a regional public mental health consortium such as the consortium established for the Region IV (Central Virginia) Acute Care Project.

For persons with serious mental illnesses having both acute and chronic care needs, a comprehensive and system-wide public mental health utilization management program that uses established, industry-accepted standardized processes does not currently exist. Such as system would require integration of multiple data sources and multiple providers and would necessitate automation on a system-wide level. Potential outcomes include improved care and reduced cost by data-derived matching of severity of illness to treatment level. These data could also be used to inform clinical and administrative best practices. The Department would need additional resources to establish the data system required to capture and report these data.

Medications Tracking

Pharmaceuticals represent an ever-increasing percentage of health care budgets in Virginia and nationally. Knowledge of individual practitioner and system wide prescribing activity is essential for cost effective and high quality delivery of mental health medications. The Department is developing a software system, MedIs, to extract and assemble data from state facility pharmacies and the Aftercare Pharmacy, which dispenses medications to CSBs. This system will increase the Department's understanding of drug usage by the entire system, by each facility, by types of services within facilities, and by individual practitioners.

MedIs data will be useful in its own right as a means of assembling and organizing data for planning drug budgets, studying prescribing patterns, making comparisons and identifying outliers. This data also can be matched with indicators of clinical progress to determine which prescriptions are working and which are not. It also will automatically update price changes to allow the Department and facilities to better manage medication expenditures.

The Department is currently implementing an enterprise system for the collection and storage of pharmacy data. The enterprise system will help ensure data integrity, automate certain functions to improve data reliability, and ease the burden on facility pharmacists through these automated functions. Reports have been developed to evaluate the utilization of drugs from a clinical and budgetary perspective and to evaluate the utilization of polypharmacy. Additional

reports will be developed to allow facilities to examine certain medication errors, such as early and late refills, and evaluate the effect of a particular medication regime on individual outcomes.

MedIs will become a valuable research tool in the coming years, allowing the Department to evaluate the impact of training and educational strategies on physician prescribing practices, from clinical and cost perspectives. Because MedIs uses existing data, such research can include both retrospective and prospective studies. For example, the Department is preparing a Guide to Medication Management that will be distributed to physicians in community and state facility programs. The intent of the Guide is to educate physicians about the clinical indications and costs of various medications. With MedIs data, the Department will be able to evaluate whether this strategy has altered the prescribing practices of physicians in the public system.

This project has generated substantial interest in the pharmaceutical industry, and several pharmaceutical companies have made small monetary contributions toward its development. However, funds do not exist to fully implement and realize the benefits of the MedIs system, which has significant potential for pay-back in cost effective prescribing activity.

Management of Potential Risks and Liabilities in State Facilities

The Department's Office of Risk and Liability Affairs continues to assist management and the workforce in proactively addressing risks and liabilities inherent in ongoing programs and daily operations. Management of risks and liabilities continues to take on new dimensions, including the Department's implementation of federal regulations governing the privacy and security of patient identifiable information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which took effect in April 2003. In addition, pursuant to §51.5-37.1 of the *Code of Virginia,* the Department reports all deaths and critical incidents to the Department for Virginia Office for Protection and Advocacy (VOPA) within 48 hours of occurrence or discovery, as well as follow-up reports of then known facts. A VOPA Incident Tracking System database has been established in Central Office to assure implementation, monitoring, and documentation of compliance.

Guardianship

There are approximately 175 residents in state facilities in need of a guardian or other type of substitute decision-maker. A similar need for guardians and substitute decision-makers exists for individuals receiving services from community providers. When no substitute decision-maker is available, state facilities and community providers can access the judicial system for court ordered treatment. This alternative provides the required authority for needed treatment, but it does not provide for the participation in decision-making that is necessary for residents who lack the capacity to participate in other aspects of their care. Court ordered treatment does not provide for individual choice. When no family member is available to serve as an authorized representative, the state facility or community provider must absorb the cost incurred by pursing the appointment of a guardian. The average fee for each guardianship proceeding and appointment is $2,000 per year.

Reduction in the Use of Seclusion and Behavioral Restraint

The provision of non-coercive treatment and care in mental health facilities, of which reduction and elimination of the use of seclusion and restraint is one component, is a priority of the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. This also is an area of particular interest to Virginia's Inspector General. Representatives of the Department and other public sector mental health clinicians and leadership from states in the southeast recently received federally sponsored training in the reduction of seclusion and restraint, including a curriculum to be used in the further development of these techniques and principles in Virginia state system. Eastern State Hospital is piloting the effort and working with Department staff to implement practices that will lead to

further reductions of seclusion and restraint in all state facilities. Expected outcomes include a reduction in individual and staff injuries, improvement in individual and family satisfaction with care, and the enhancement of a non-coercive, respectful, empathic treatment environment.

Concomitant with this initiative and a critical part of it will be training in behavioral interaction. The Department and Therapeutic Options, Inc.© developed the behavior interaction training program jointly to meet the specific needs of individuals served in state facilities. This training program is distinguished by its focus on improving therapeutic communications between individuals and treatment providers. It utilizes the principles of applied behavior analysis and psychosocial rehabilitation to train caregivers to more appropriately interact with individuals in a manner that supports the therapeutic interventions of the treatment team. Over the next two years, all facility staff will be trained to utilize the new techniques. The training program also will be made available at a reduced cost to community services boards through a special contractual agreement with Therapeutic Options, Inc.©.

A symposium on the legal ramifications of behavioral restrictions, treatment alternatives, and successful seclusion and restraint reduction strategies is being developed to educate state facility and community providers on the risks of and alternatives to seclusion and restraint. The training will highlight proven strategies in the Virginia public service system and nationally, drawing upon the expertise of facilities that have reduced or eliminated their use of restrictive measures and featuring national experts in this area. The program will explore the role of psychotropic medications as a contributing factor to the development of symptoms that may necessitate the use of restrictive techniques and their effectiveness in alleviating the underlying psychiatric symptoms that often result in volatile behaviors.

The Department has developed a central, automated seclusion and restraint database to evaluate the effectiveness of its educational programs and reduction strategies and to identify areas for targeted improvements. The database will generate a series of standardized reports that will allow facilities to evaluate their utilization of seclusion and restraint and the effects of such utilization on the health and safety of individuals and staff; it will allow them to assess staff use of alternative interventions; and it is designed to improve benchmarking among clusters of facilities serving similar populations. The database will allow the Department to conduct research into conditions that may contribute to the use of seclusion and restraint (for example, the effect on staffing ratios and the use of temporary and agency staff on seclusion and restraint use).

Goals, Objectives, and Action Steps

Goal 22: Enhance the Department's oversight of quality of care and protection of individuals receiving mental health, mental retardation, and substance abuse services and developmental disabilities and brain injury services.

Objectives:

1. Develop a risk-based system of licensing with the goal of protecting individuals receiving services and maximizing staff resources.

Action Steps:

a. Seek funding to add two licensing specialists necessary to address increasing requirements to license additional providers and services.

b. Seek legislation to change the existing inspection requirement to a risk-based system of licensing inspections during the 2004 General Assembly session.

c. Promulgate regulatory changes by December 2004.

d. Develop a system to identify non-residential services that will require more frequent inspections by December 2004.

2. Identify areas of risk related to citations, complaints, and incidents and staff responses.

Action Steps:

a. Analyze data by January 2004.

b. Develop recommendations for office procedures by April 2004.

c. Train staff by June 2004.

d. Develop guidance for providers by June 2004.

***3. Dev*elop a cooperative methodology for licensing residential facilities.**

Action Steps:

a. Complete HJR 199 Report by November 1, 2003 for review by the General Assembly.

b. Work with DSS to implement the HJR 199 recommendations approved by the General Assembly.

***4.* License brain injury services.**

Action Steps:

a. Introduce legislation in 2004 General Assembly to authorize the Department to license residential services for individuals with brain injuries to be provided under a Medicaid Brain Injury Services Waiver.

b. Promulgate emergency regulations by September 2004 and final regulations by September 2005.

c. Accept applications for new providers by September 2004.

Goal 23: Assure the rights of each individual receiving services from providers of mental health, mental retardation, or substance abuse services through a high quality, effective, efficient, and responsive human rights system.

Objectives:

1. Promote the concept of and training in treatment without coercion in state operated facilities and community-based services and hospitals.

Action Steps:

a. Monitor provider use of seclusion and restraint, including the Aggressive Management program at Central State Hospital.

b. Identify needs for future training and advocacy regarding the use of seclusion and restraint or the Aggressive Management programs.

c. Provide training for OHR staff so they become knowledgeable about and can assist the Department in implementing the new Behavioral Intervention/Interaction Management program developed by the Department in consultation with Therapeutic Options, Inc.©.

2. Promote the concepts of treatment in the most integrated settings and individual and family choice that are central to the Olmstead Decision.

Action Steps:

a. Monitor the appropriate movement of discharge ready individuals from state facility to community-based services.

b. Provide reports on the status of discharge ready individuals to the State Human Rights Committee, local human rights committees, and human rights advocates.

c. Receive input and consultation from the State Human Rights Committee on the Discharge Protocols and process by December 2003.

3. Increase the effectiveness and efficiency of the LHRC system.

Action Steps:

a. Identify specific aspects of the LHRC system and process that can be improved while maintaining the highest level of individual protections and reducing provider administrative burden.

b. In collaboration with services system partners, begin the revision process of the human rights regulations by the fall of 2004 to implement recommended changes.

4. Promote workable systems for rights protections by conducting fair, accurate, and consistent human rights monitoring activities across the state.

Action Steps:

a. Formalize the documentation and reporting of monitoring activities.

b. Use the Monitoring Tool for all monitoring activities.

5. Increase the availability of human rights advocates to individuals in accordance with the recommendations in House Document No. 21 (2001); "Evaluating the Human Rights Advocates in State Facilities and Community Programs."

Action Steps:

a. Seek funding to increase by two the number of human rights advocates.

6. Revise the human rights regulations.

Action Steps:

a. In collaboration with services system partners, design the approach for revising the human rights regulations in accordance with the APA process.

b. Begin the periodic review of the human rights regulations no later than the fall of 2004 and complete it by the fall of 2005.

c. Promulgate revised human rights regulations.

d. Implement the revised human rights regulations.

e. Provide statewide training within 90 days of the promulgation of the revised regulation.

7. Ensure that individuals who lack capacity to provide informed consent have uninterrupted access to appropriate treatment and services.

Action Steps:

a. Seek funds to increase the number of guardians and other substitute decision-makers for individuals receiving services in state facilities and community programs.

b. In collaboration with services system partners, pursue specific options for increasing the availability and training of individuals to serve as surrogate decision-makers.

Goal 24: Evaluate the need for and effectiveness of uniform clinical guidelines as a tool for improving the quality of state facility treatment, care, and clinical services.

Objectives:

1. Utilize new and existing facility data and systems to evaluate the effectiveness of uniform clinical guidelines.

Action Steps:

a. Establish mechanisms to provide the Clinical Services Quality Management Committee (CSQMC) with continuous feedback and data about the effectiveness of treatment, care, and clinical service requirements established by uniform clinical guidelines.

b. Establish mechanisms to provide the CSQMC with data about important aspects of care, serious events, and other information that reflect the process and outcomes of treatment, care, and clinical services.

c. Through the CSQMC, routinely evaluate the data to ascertain the effectiveness of uniform clinical guidelines and the need for revisions and to identify problems in service delivery that may require new uniform clinical guidelines.

Goal 25: Ensure that quality management review functions at the state facility and Department levels are implemented according to clearly articulated policies and procedures.

Objectives:

1. Establish and maintain structures and processes to protect the privileges provided by the Health Care Quality Improvement Act of 1986 for case referral, information review activities, data collection, external consultation, record keeping, and reporting.

Action Steps:

a. Develop procedures with state facilities for the confidential transfer of information between facility Quality Management programs and the CSQMC.

b. Develop Central Office procedures to safeguard and maintain the confidentiality of individual information and quality management review activities that are generated by the CSQMC.

c. At least annually, provide for an independent review of the safeguards in place to protect individual information and the privileges granted to the CSQMC by the *Health Care Quality Improvement Act of 1986.*

2. Periodically evaluate the functions, activities, and effectiveness of the CSQMC, as they relate to clinical case review, leadership, and oversight of important aspects of quality care.

Action Steps:

a. Develop standard process and clearly articulated, measurable criteria for review.

b. Work with state facility quality managers to develop an independent review process to evaluate the effectiveness of the CSQMC in providing leadership oversight and improving the quality of clinical care.

c. Submit a written report of the results and recommendations for improvement to the Commissioner and the members of the CSQMC.

Goal 26: Assure that publicly funded services provided in state facilities and CSBs are based on sound research that assures the highest quality treatment and the best clinical outcomes for the residents of the Commonwealth.

Objectives:

1. Expand the Department's research capabilities to conduct research specific to the Commonwealth's services system needs in order to supplement the available evidence for providing critical treatments to persons with mental disabilities.

Action Steps:

a. Continue to develop the MedIs system to conduct research in the area of psychotropic medication practices among community and facility providers.

b. Utilize the Seclusion and Restraint Database to conduct research on effective strategies to manage volatile behavior among individuals in state facilities.

c. Identify the critical issues in the treatment and care of persons with mental disabilities in Virginia's public mental health, mental retardation, and substance abuse system.

d. Develop a research agenda, based on the system's critical treatment issues that will enhance the available evidence with a focus on the specific populations and settings in Virginia's public sector.

Goal 27: Implement a comprehensive and system-wide approach to public mental health utilization.

Objectives:

1. Develop a utilization management infrastructure for state facilities and CSBs.

Action Steps:

a. Establish clinical criteria for specific levels of service utilization.

b. Develop a proposal and cost–benefit analysis for an automated database that integrates multiple data sources and multiple providers.

c. Generate support for the collection of utilization management data among providers through training, education, and the dissemination of relevant literature.

Goal 28: Develop the system's capacity to improve the medication practices of physicians, pharmacists, and nurses who have a role in the medication management process in community and state facility services.

Objectives:

1. Continue to develop the MedIs system for inpatient and community reporting of pharmacy utilization.

Action Steps:

a. Continue implementation of the Enterprise system to centralize facility pharmacy and Aftercare Pharmacy data.

b. Develop MedIs reports for stat and PRN medication usage, medication history, and clinical outcomes.

c. Expand the reporting capabilities of the MedIs software to include reports for the State Aftercare Pharmacy, which provides medications to many individuals served by CSBs.

d. Conduct a study to evaluate the use of MedIs reports for clinical and administrative decision-making and their impact on the prescribing practices of individual practitioners, treatment team decision-making, quality oversight processes, and medication costs.

2. Expand the capabilities of the MedIs system to include automated components for clinical outcomes measures.

Action Steps:

a. Survey state facilities to identify the instruments for measuring outcomes, such as the BPRS, that are most frequently used in facility programs.

b. Estimate the feasibility of developing an automated system to score and evaluate outcomes and the cost of linking this data to the MedIs pharmacy data system.

c. Develop a proposal for a short-term, non-automated pilot project to evaluate the benefits of such software development, in terms of improving medication outcomes, cost savings, and user satisfaction with the results.

d. Based on the results of the pilot, develop a funding proposal.

Goal 29: Reduce the utilization of seclusion and behavioral restraint in state facilities.

Objectives:

1. ***Provide ongoing education and training to all levels of staff in state facility and community programs to promote alternatives to the use of coercive techniques.***

   Action Steps:

   a. Hold a symposium on the legal, safety, and clinical ramifications of seclusion and restraint use.
   b. Continue to train state facility employees in all job categories on therapeutic interactions that are designed to reduce the use of coercive techniques.
   c. Provide ongoing training to community and facility providers on the causes of volatile symptoms and alternative strategies for managing such behaviors.

2. **Continuously evaluate the utilization of restrictive procedures and their effects on the health and safety of individuals and staff.**

   Action Steps:

   a. Through the CSQMC, routinely review standardized seclusion and restraint data and reports to evaluate the effectiveness of restraint reduction strategies and training programs.
   b. Use seclusion and restraint data to study the relationship between staffing strategies and the use of coercive techniques.
   c. Use MedIs data in conjunction with seclusion and restraint data to evaluate the role of specific pharmaco-therapy as a contributing factor and as an effective treatment for the psychiatric symptoms that may necessitate the use of seclusion and restraint.

Promoting Self-Advocacy, Self Determination, and Empowerment for Individuals Receiving Mental Health, Mental Retardation, or Substance Abuse Services and Their Families

Mental Health

The Virginia mental health system has been enhanced and improved through the involvement of well-informed individuals and their families. This has been and continues to be a priority of the Department. Federal Mental Health Block Grant funds are used to support numerous activities across the state to educate individuals and their families about mental illnesses and their treatments. These activities have been accomplished through contracts with the Virginia Human Services Training Center ($74,928) to train individuals receiving services as peer counselors, National Alliance for the Mentally Ill (NAMI)-Virginia to provide statewide education to individuals and their families ($100,000), Parents and Children Coping Together (PACCT) to educate parents and caregivers of SED children across the state ($75,000), the Virginia Organization of Consumers Asserting Leadership (VOCAL) to provide technical assistance to consumer-run programs ($60,000), for Statewide Consumer-Run Programs, to provide peer-run services in consumer-operated programs and centers ($290,000), the Family Support Services Project ($32,500) in southwest Virginia, and the Southwest Virginia Consumer and Family Involvement Project ($42,500).

The Virginia Human Services Training Center is located at the Piedmont Virginia Community College with support from the Region Ten CSB. The training is a collaborative effort of the Department, CSBs, Department of Rehabilitation Services, and the community college. Communities nominate individuals to be trained in the skills needed to provide peer counseling back at their home CSBs. Each year, approximately 15 individuals are trained.

With block grant support, NAMI-Virginia has conducted assessments of family education needs in Virginia and provided training across the state. Over 28 new or existing family education

groups were developed or supported to inform individuals and their families about mental illnesses and their treatments. Technical assistance was provided to 50 family education/support groups using programs such as Mutual Education, Support and Advocacy (MESA), NAMI's Family-to-Family, NAMI Texas' VISIONS, and the Wellness Recovery Action Plan (WRAP).

Also with block grant support, PACCT has trained over 100 family members and caregivers of children with serious emotional disturbance. Its Family Involvement Workshop provided information about the service system in Virginia and taught the skills needed to effectively access services for children in need. A Family Leadership train-the-trainer workshop was conducted to train family members in the skills needed to conduct their own Family Involvement Workshop. A toll-free telephone number has been maintained to provide information and referral for mental health services for children across the state. Quarterly newsletters concerning mental health services for SED children have been published and distributed across Virginia.

The Family Support Services Project was established to develop and assist family support groups with education, support, and advocacy. This effort is directed to family members of those with serious mental illness and involves close collaboration with CSBs in the Southwest region and the Southwestern Virginia Mental Health Institute. Project activities include a toll-free information and referral line and "Ask the Doctor" videoconferences between support groups and the Institute.

The Southwest Virginia Consumer and Family Involvement Project is a consumer-driven project, the purpose of which is to prepare persons with mental illness to become meaningfully involved in the mental health system by providing education, advocacy, and support. Project activities are aimed toward increased individual and family participation in decision-making and policy formation, in service planning, and in the delivery and evaluation of publicly funded mental health services. These activities include the coordination of LEAP (Leadership-Empowerment-Advocacy Program) Training, MESA Training, Peer Counselor Training, and Community Integration Groups.

In addition to the programs and activities described above, the Virginia Mental Health Planning Council has partnered with the Mental Health Association of Virginia (with $150,000 in support from a Center for Mental Health Service's Community Action Grant) to promote the best practice of formally training individuals receiving services to be members of boards and serve on policy making entities. Through the Consumer Education and Leadership Training (CELT) program, individuals receiving services from across the state have received specialized training in the skills needed to effectively represent services recipient issues on boards and committees. Unfortunately, that source of federal funding is no longer available. A small amount of one-time funding is now available to support some ongoing CELT activities.

Mental Retardation

Involvement by individuals receiving services and families is a critical component of all services supported through the Department's Office of Mental Retardation Services (OMRS). Child and family services, offered statewide through Infant and Toddler Connection (Part C), require the family to participate in each step of planning and delivery of services, since the goal of services is to prepare families to support their children with disabilities and developmental delays. OMRS also administers the Family Support funds, distributed annually to localities to offer flexible support to families who provide care for adults and children at home, as well as a federal Day Care subsidy program that supports parents of children with disabilities in finding appropriate day care settings.

Individuals receiving services and families are involved in the development of Medicaid Waiver plans of care, and they must be part of the annual planning process for Waiver services. The OMRS provides technical assistance to all providers in techniques of person-centered planning. During 2003, the Mental Retardation Waiver introduced three "consumer-directed" services,

meaning the individual or family may recruit, schedule, and fire, if necessary, workers of their choice. Within six months after the service became available, approximately 450 individuals or families had been enrolled in these new services. During 2003, the OMRS participated in development of the new Independence Plus Waiver, which would give families the option of a Self-Determination model, in which individuals or families can negotiate with potential workers for services and rates for services. Once approved by CMS, this will greatly empower individuals and families to have much greater control over their services.

Individuals receiving services and families are also involved in the policy and planning process. All Part C workgroups and administrative committees include family members, and the oversight committee appointed by the Governor, the Virginia Interagency Coordinating Council, has several family members. The Mental Retardation Waiver Task Force, established in 2001 to rethink the services and direction of community-based Waiver services, included individuals and families, including families of residents in state training centers. The Task Force was reconvened to develop a Waiver renewal that could address any additional changes needed in Virginia, and again, many families were involved in that effort.

The OMRS is involved in a grant project through the Virginia Board for People with Disabilities, beginning in 2003, that assists individuals with developmental disabilities in Virginia to become self-advocates. The project, called New Voices, will enable individuals with mental retardation to assume a greater role in deciding their future. At least one participant is a lifelong resident of a training center seeking to live in the community.

Each year, all CSBs give family satisfaction surveys to families of people with mental retardation receiving case management services. Families return the surveys directly to the OMRS and results are analyzed to determine individual or family member perceptions of services. Results are shared with each CSB.

Substance Abuse

Consumer advocacy for substance abuse services has been slow to develop due to stigma, shame, and fear. Initially organized in 1997 as a grassroots advocacy organization, the Substance Abuse and Addiction Recovery Alliance (SAARA) of Virginia continues to make strong inroads in Virginia by establishing and supporting local affiliates. Now incorporated as a 501c3 nonprofit organization, the mission of SAARA of Virginia is to maximize “the power of the people to advocate for treatment and recovery in order to prevent the harmful effects of substance abuse upon families, businesses, and the community.”

Membership is open to individuals and organizations. SAARA’s goals include informing the public about the impact of addictions and the resources and services available for treatment and prevention; developing and sustaining SAARA as a viable organization; communicating with the general public and legislative bodies; and becoming fiscally self-sustaining. As a part of its goal to become self-sustaining, its board of directors has received training in fund raising and is implementing strategies to encourage corporate memberships. SAARA publishes a quarterly newsletter, *The Recovery Advocate*, has established a website (www.saara.org), and conducts an annual conference for members and interested persons.

Goals, Objectives, and Action Steps

Goal 30: Increase opportunities for individual and family involvement.

Objectives:

1. ***Maintain current avenues for individual and family involvement, while seeking to widen the scope of individual involvement in all aspects of the mental health system.***

   Action Steps:

a. Continue to support the Mental Health Planning Council as it strives to have a meaningful voice in system development.
b. Provide funding to support individual and family involvement in restructuring and re-investment planning processes and meetings.
c. Seek ways to build and link the network of parents of children and adolescents with mental health, mental retardation and substance abuse service needs.
d. Promote and seek additional funding for LEAP and the CELT Leadership Academy training to better prepare individuals and family members for meaningful roles in planning and policy making activities.
e. Encourage VOCAL and consumer-run programs throughout Virginia to keep their members fully informed about opportunities to be involved in systems change initiatives.

Goal 31: Improve opportunities for individual and family education and training.

Objectives:

1. Increase the number of individuals and family members who receive training.

Action Steps:

a. Contract with community programs to provide individual and family education training.
b. Promote publicity about new and existing programs through CSBs, NAMI, and MHAV.
c. Work with consumer organizations across the state to involve more individuals in WRAP and other recovery-based peer-to-peer training programs.
d. Seek funding to expand MESA, and Family-to-Family education across the state.
e. Implement the evidence-based practice of family psycho-education in at least one CSB in each region.

Goal 32: Promote and support the implementation of mental health programs that foster empowerment, peer support, and recovery-based services.

Objectives:

1. Develop, in collaboration with the Mental Health Planning Council and other services system partners, action steps for transforming the current system of services and supports toward a recovery orientation.

Action Steps:

a. Establish an Advisory Committee comprised of Mental Health Planning Council members, CSB providers, and interested consumers to develop a recovery orientation work plan.
b. Engage national experts in a long-term consultative initiative to assist the Commonwealth and the Advisory Committee in developing and implementing the work plan.
c. Design and implement an evaluation methodology to provide regular feedback on progress in transforming the services system.

2. Promote the establishment and expansion of consumer-run programs throughout the state to enhance opportunities for individual choice and self-determination.

Action Steps:

a. Seek funding to develop new and expand existing consumer-run centers.
b. Provide funding and support for the operation of a statewide network of mental health consumers and local consumer organizations to increase their voice and representation.

c. Develop and implement a statewide recovery education program run by and for individuals receiving mental health services.

d. Establish a consensus policy for implementing independent consumer-run programs that encourage and support consumer determination and leadership.

e. Work with VOCAL to promote and support the establishment of consumer-run programs in each CSB service area, provide technical support, and encourage greater consumer choice in areas where there are no consumer-run alternatives.

Goal 33: Provide individuals and families with the opportunity, at both the systems and the individual levels, to determine the types of services they receive, as well as the opportunity to evaluate the quality of those services.

Objectives:

1. Expand the number of individuals receiving services and families involved in the planning process.

Action Steps:

a. Conduct more "focus group" or regional meetings in targeted areas, rather than relying on centralized meetings that fewer people can attend, due to work schedules or other resources.

b. Support the "New Voices" project to develop more direct input and understanding of the messages from individuals with mental retardation.

c. Schedule a minimum of 3 focus groups annually, inviting individuals and families who represent different types of issues, e.g., access to supported employment services or supporting family members with a dual diagnosis.

d. Review the number of individuals and families participating in training projects in which OMRS participates.

2. Assure greater opportunities for individual and family direction in their own services.

Action Steps:

a. Continue working with DMAS and the Independence Plus workgroup to obtain federal approval for a self-determination-oriented Medicaid program and expand opportunities for individual and family participation in consumer-directed services through the MR Waiver.

b. Determine the satisfaction of families and individuals who receive services through a survey method.

Goal 34: Reduce the stigma and shame associated with substance abuse that inhibit people with substance use disorders from seeking help and restrict available resources to support treatment and prevention and increase the impact of individual experience on the service delivery system.

Objectives:

***1. Facilitate the development and growth of SAARA as a fiscally independent organization with a strong, viable membership*.**

Action Steps:

a. Partner with SAARA in developing and implementing initiatives that will educate members of the general public as well as targeted groups, such as family members and physicians about substance use disorders and evidence-based treatment.

b. Continue to contract with SAARA to develop individual-oriented products and services that foster advocacy in the community.

c. Continue to provide technical assistance to SAARA by utilizing national and federal resources.
d. Continue to support SAARA in pursuing and developing sustainable fiscal resources.

Supporting System Collaboration and Integration

System Leadership Council

The System Leadership Council evolved from the FY 2001 Community Services Performance Contract negotiations, reflecting a desire to include a mechanism in the contract to provide continuity, enhance communications, and address and resolve systemic issues and concerns. The Department, pursuant to provisions in that Performance Contract, established the System Leadership Council in August 2000. The Council includes representatives of CSBs, state facilities, local governments, the State Board, and the Department's Central Office. Subsequent contracts from FY 2002 to the present have continued the Council. For FY 2004, the Council provisions were moved from the Performance Contract to the Central Office, State Facility, and Community Services Board Partnership Agreement. The Agreement states that the System Leadership Council shall, among other responsibilities:

- Identify, discuss, and resolve issues and problems;
- Examine current system functioning and identify ways to improve or enhance the operations of the public mental health, mental retardation, and substance abuse services system; and
- Identify, develop, propose, and monitor the implementation of new service modalities, systemic innovations, and other approaches for improving the accessibility, responsiveness, and cost effectiveness of the publicly funded mental health, mental retardation, and substance abuse services system.

The Council serves as a coordinating mechanism to discuss issues and problems from a systemic point of view in a calm environment to reach as much agreement as it can, providing continuity, enhanced communication, and a consistent perspective over time. The Council's work and recommendations affect the organization and delivery of publicly funded services in the Commonwealth. The Council continues to discuss a broad range of issues and support various initiatives, including performance contract and reporting requirements, workforce concerns, aftercare pharmacy and medications issues, and discharge protocols and census management. For instance, the State Pharmacy Task Force established by the Council has significantly affected the operations of the pharmacy and the delivery of psychotropic medications across the state.

Services System Partnerships

The Department took a new approach in developing the FY 2004 Community Services Performance Contract. In collaboration with CSB representatives, Department staff developed the new contract from a blank slate, rather than just revising the previous year's contract. This produced a greatly shortened and more focused FY 2004 Performance Contract. It also produced two new documents, the Partnership Agreement and the Community Services Contract General Requirements Document. Full texts of all three documents are available on the Department's web site at www.dmhmrsas.state.va.us.

The Partnership Agreement describes the values, roles, and responsibilities of the three operational partners in the public mental health, mental retardation, and substance abuse services system: CSBs, state facilities, and the Department's Central Office. It reflects the fundamental, positive evolution in the relationship between CSBs and the Department to a more collegial partnership. It recognizes the unique and complementary roles and responsibilities of the Department and the CSBs as the state and local authorities for the public mental health,

mental retardation, and substance abuse services system. The goal of the Agreement is to establish a fully collaborative partnership process through which the CSBs, Central Office, and state facilities can reach agreements on operational and policy matters and issues.

Although this partnership philosophy helps to ensure positive working relationships, each partner has a unique role in providing public mental health, mental retardation, and substance abuse services. These distinct roles promote varying levels of expertise and create opportunities for identifying the most effective mechanisms for planning, delivering, and evaluating services.

Central Office

1. Ensures through distribution of available funding that a system of community-based and state facility resources exists for the delivery of publicly-funded services and supports to Virginia residents with mental illness, mental retardation, or alcohol or other drug dependence or abuse.
2. Promotes at all locations of the public mental health, mental retardation, and substance abuse service delivery system (including the Central Office) quality improvement efforts that focus on individual outcome and provider performance measures designed to enhance service quality, accessibility, and availability.
3. Supports and encourages the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, monitoring, and evaluation.
4. Ensures fiscal accountability that is required in applicable provisions of the *Code of Virginia,* relevant state and federal regulations, and State Mental Health, Mental Retardation and Substance Abuse Services Board policies.
5. Promotes identification of state-of-the-art programming and resources that exist as models for consideration by other operational partners.
6. Seeks opportunities to affect regulatory, policy, funding, and other decisions made by the Governor, the Secretary of Health and Human Resources, the General Assembly, other state agencies, and federal agencies that interact with or affect the other partners.
7. Encourages and facilitates state interagency collaboration and cooperation to meet the service needs of consumers and to identify and address statewide interagency issues that affect or support an effective system of care.
8. Serves as the single point of accountability to the Governor and the General Assembly for the public system of mental health, mental retardation, and substance abuse services.
9. Problem solves and collaborates with a CSB and State Facility together on a complex or difficult consumer situation when the CSB and State Facility have not been able to resolve the situation successfully at their level.

Community Services Boards

1. Serve as the single points of entry into the publicly funded system of services and supports for Virginia residents with mental illnesses, mental retardation, or alcohol or other drug dependence or abuse.
2. Serve as the local points of accountability for the public mental health, mental retardation, and substance abuse service delivery system.
3. To the fullest extent that resources allow, promote the delivery of community-based-services that address the specific needs of individual consumers with a focus on service quality, accessibility, and availability.
4. Support and encourage the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, monitoring, and evaluation.

5. Establish services and linkages that promote seamless and efficient transitions of consumers between state facility-based services and local community-based services.
6. Promote sharing of program knowledge and skills with operational partners to identify models of service delivery that have demonstrated positive consumer outcomes.
7. Problem solve and collaborate with State Facilities on complex or difficult consumer situations.
8. Encourage and facilitate local interagency collaboration and cooperation to meet the other services and supports needs of consumers.

State Mental Health and Mental Retardation Facilities

1. Provide psychiatric hospitalization and other services to consumers identified by CSBs as meeting statutory requirements for admission.
2. Within the resources available, provide residential and training services to persons with mental retardation identified by CSBs as needing those services.
3. To the fullest extent that resources allow, provide services that address the specific needs of individual consumers with a focus on service quality, accessibility, and availability.
4. Support and encourage the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, monitoring, and evaluation.
5. Establish services and linkages that promote seamless and efficient transitions of consumers between state facility-based services and local community-based services.
6. Promote sharing of program knowledge and skills with operational partners to identify models of service delivery that have demonstrated positive consumer outcomes.
7. Problem-solve and collaborate with CSBs on complex or difficult consumer situations.

Core Values

The partners entered into the Agreement to improve the quality of care provided to consumers and to enhance the quality of consumers' lives. While they are interdependent, each partner works independently with both shared and distinct points of accountability, such as state, local, or federal government, other funding sources, consumers, and families, and all partners embrace common core values. The following core values guide the operational partners in developing and implementing policies, planning services, making decisions, providing services, and measuring the effectiveness of service delivery.

1. The Central Office, state facilities, and CSBs are working in partnership; we hold each other accountable for adhering to our core values.
2. As partners, we will focus on fostering a culture of responsiveness instead of regulation, finding solutions rather than assigning responsibility, emphasizing flexibility over rigidity, and striving for continuous quality improvement, not just process streamlining.
3. As partners, we will make decisions and resolve problems at the level closest to the issue or situation whenever possible.
4. Services should be provided in the least restrictive and most integrated environment possible. Most integrated environment means a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible (28 CFR pt. 35, App. A, p. 450, 1998).
5. Community-based services and state facility-based services are integral components of a seamless public system of care.
6. The goal of all components of our public system of care is that the persons we serve recover, realize their fullest potential, or move to independence from our care.

7. The consumer's or legally authorized representative's participation in treatment planning and service evaluation is necessary and valuable and has a positive effect on service quality and outcomes.
8. The consumer's responsibility for and active participation in his or her care and treatment are very important and should be supported and encouraged whenever possible.
9. Consumers have a right to be free from abuse, neglect, or exploitation and to have their basic human rights assured and protected.
10. Choice is a critically important aspect of consumer participation and dignity, and it contributes to consumer satisfaction and desirable outcomes. Consumers should be provided with responsible and realistic opportunities to choose as much as possible.
11. Family awareness and education about a person's disability or illness and services are valuable whenever they are supported by the individual with the disability.
12. Whenever it is clinically appropriate, children and adolescents should receive services provided in a manner that supports maintenance of their home and family environment. Family includes single parents, grandparents, older siblings, aunts or uncles, and other individuals who have accepted the child or adolescent as a part of their families.
13. Children and adolescents should be in school and functioning adequately enough that the school can maintain them and provide an education for them.
14. Independent living or community residency in safe and affordable housing with the highest level of independence possible is desired for adult consumers.
15. Gaining employment, maintaining employment, or participating in employment readiness activities improves the quality of life for adults with disabilities.
16. Lack of involvement or a reduced level of involvement with the criminal justice system, including court-ordered criminal justice services, improves the quality of life of all individuals.
17. The public mental health, mental retardation, and substance abuse services system serves as a safety net for individuals, particularly people who are uninsured or under-insured, who do not have access to other service providers or alternatives.

Linkages with Local Government

The 134 cities or counties in Virginia continue to be vital members of the state-local partnership that enables the provision of community mental health, mental retardation, and substance abuse services to almost 200,000 Virginians annually. Local governments partner with the Commonwealth through the CSBs that they established and maintain and through their financial and other support of services offered by those CSBs. The Department needs to continue communicating with local governments through their CSBs about their concerns and ideas, such as ways to enhance service quality, effectiveness, and efficiency. As demands for services continue to exceed the capacity of the current services system to meet them and as related requirements for more effective management and coordination of services proliferate, new and innovative approaches need to be considered that preserve the strengths and advantages of the current public services system and the state-local partnership, while responding to these new demands.

Linkages with Private Providers

Private provider participation in the services system is another major strength of the public mental health, mental retardation, and substance abuse services system. This participation has grown dramatically over the last six years. A major factor influencing this growth has been the continued although, less rapid expansion of Medicaid MR Home and Community-Based Waiver (MR Waiver) services.

Despite this significant expansion, two limiting phenomena have been apparent in this process: the absence of private providers in certain parts of the state and the need for private providers to offer more of particular types of services. For example, there are few private providers in many rural parts of Virginia. Similarly, few providers offer community-based intermediate care facility services for individuals with mental retardation (ICF/MR). ICF/MR services represent a particular opportunity for growth, given the Supreme Court Olmstead decision and the Medicaid funding stream for this service. Also, some of the newer or smaller providers have experienced difficulties in establishing sound operations in their efforts to offer scarce and greatly needed services. This has been evident with some new vendors of MR Waiver residential services.

Consequently, the development of private providers needs to be fostered and supported in various parts of the state. This includes encouraging existing private providers to expand their operations to other parts of the state, to begin offering other services, and to increase their current capacities. This also includes identifying and, where possible, offering incentives to promote the development of new private providers. These initiatives should be joint efforts by the Department and CSBs, working closely with the private provider community.

A number of conditions have limited, reduced or jeopardized private provider participation in the publicly funded mental health, mental retardation, and substance abuse services system.

- Medicaid State Plan Option and MR Waiver reimbursement rates, with only a few exceptions, have not been adjusted in over 13 years. In some areas of the state, Medicaid fees reportedly do not cover the cost of providing services; consequently, private providers are not able to offer those services on an economically sustainable basis.
- Third party insurance coverage for services continues to decline under managed health care, in terms of services covered, amounts of services allowed, and amounts paid for services.
- A growing proportion of individuals have inadequate or no health insurance coverage.
- Information about potential private providers may not be readily available to CSBs when their staffs are developing individualized services plans.
- There is a perceived or actual resistance by some private providers, especially residential or inpatient providers, to serving individuals receiving CSB services, because of the severity of the individuals' disabilities or lack on information about effective treatment modalities.
- Market forces have led to shifts in private sector service provision, despite the obvious and significant public sector needs for particular services. A clear and immediate example of this condition is the marked and continuing reduction in local private psychiatric inpatient hospital beds in some parts of the state that are available to CSBs and the Department. Some providers have ceased offering this service due to inadequate reimbursement rates; others have converted their inpatient beds to other uses, such as Comprehensive Services Act residential beds, which may be less costly to operate and more easily reimbursable.
- Like public providers, the private sector is experiencing increasing difficulties in recruiting and retaining qualified staff, including professionals, such as nurses and other clinical staff, and para-professionals, such as residential aides and personal care staff.
- The large capital cost sometimes associated with the implementation of new services, particularly residential services, may inhibit private sector participation.
- Finally, the significant start up costs, such as staff recruitment and training, equipment purchases, acquisition of space, and operating at less than full capacity during implementation that are often required to initiate a new service may make it difficult for smaller providers to do so, limiting their participation in the publicly-funded services system.

Interagency Relationships

The Report of the President's New Freedom Commission on Mental Health identified fragmentation as a serious problem at the state level. The Report stated that state mental health authorities have "enormous responsibility to deliver mental health care and support services, yet they have limited influence over many of the programs individuals and families need." (*Achieving the Promise: Transforming Mental Health Care in America*, p. 33). This fragmentation exists for mental retardation and substance abuse services and supports as well.

In an effort to overcome the inherent fragmentation resulting from existing organization and financing of federal and state programs providing services and supports to individuals receiving mental health, mental retardation, and substance abuse services, the Department maintains collaborative linkages, partnerships, and activities with a number of state agencies. These include the Department of Housing and Community Development (DHCD), Department of Rehabilitative Services (DRS), the Department of Medical Assistance Services (DMAS), the Department of Social Services (DSS), the Department of Corrections (DOC), the Department of Criminal Justice Services (DCJS), the Department of Juvenile Justice (DJJ), the Virginia Department of Health (VDH), the Department for the Blind and Visually Impaired (DBVI), the Department for the Deaf and Hard of Hearing (DDHH), the Department of Education (DOE), the Virginia Employment Commission (VEC), the Virginia Office for Protection and Advocacy (VOPA), the Virginia Housing Development Authority (VHDA). Following are descriptions of major interagency collaborative activities.

Medicaid

The State Medical Assistance Plan was amended in 1990 to cover specific mental health and mental retardation services. Covered mental health community services include intensive in-home services for children and adolescents, therapeutic day treatment for children and adolescents, day treatment/partial hospitalization, psychosocial rehabilitation, crisis intervention, intensive community treatment, crisis stabilization, and mental health support services. Community mental retardation services covered under the MR Waiver include residential support, day support, supported employment, personal assistance, respite care, environmental modification, nursing services, assistive technology, therapeutic consultation, and crisis stabilization. Targeted mental health and mental retardation case management services are also covered under the Plan. Substance abuse residential and day treatment services for pregnant and postpartum women were added in 1997.

For mental health services, prior to FY 1991, fees comprised 11 percent of the overall CSB operating budget. In FY 1991, the first year of implementation of mental health State Plan Option and Targeted Case Management services, $57 million in fees were collected. This comprised 19 percent of total CSB funding. In FY 2002, Medicaid reimbursement to CSBs for State Plan Option services totaled $77,911,849, comprising approximately 35 percent of CSB budgets. This percentage is now much greater for some CSBs, particularly those with multi-jurisdictional operating boards, comprising as much as 50 to 70 percent of CSB budgets. The increasing prominence of Medicaid funding in CSB budgets has emphasized the interagency relationship between the Department and DMAS.

While DMAS is the single state agency responsible to the U.S. Centers for Medicare and Medicaid Services (CMS) for oversight of all Medicaid-funded services, the Department plays a critical role in policy development, provider development, education and training of providers, and preauthorization of MR Waiver services. To an increasing degree, the Department is an integral partner in developing quality assurance measures and provider oversight. In accordance with an interagency agreement, the partnership between DMAS and the Department related to the administration of the MR Waiver is intended to assure that:

- Recipients of Medicaid-reimbursed community-based mental retardation services meet eligibility requirements;

- Providers are aware of standards, regulations, and policies governing their operation;
- Providers are afforded opportunities to receive information regarding program expectations;
- Virginia is proactive in assuring that the delivery of Medicaid-reimbursed community-based services are consistent with CMS expectations; and
- Medicaid-reimbursed community-based mental retardation services are appropriate for supporting Virginia residents in community living.

Through this partnership, the Department maintains a daily working relationship with DMAS related to MR Waiver policy development and interpretation, preauthorization of Waiver services, and follow-up from utilization reviews. The Department works with all CSBs to offer training for new MR Waiver providers, new Medicaid regulations. It also provides other types of training, such as case management, to enhance the delivery of Medicaid-funded services.

Collaboration with DMAS is a cornerstone of the Department's interagency relationships, with Medicaid reimbursement now being the single largest source of funding for most CSBs. DMAS is an essential partner with the Department in providing mental health care in Virginia. The two agencies communicate regularly through a variety of venues, including regular policy consultations, review of proposed provider manual and regulatory changes, and a quarterly meeting between the Department, DMAS, and representatives of the VACSB. The Department also participates on the DMAS Managed Care Advisory Council that meets quarterly to advise DMAS on managed care issues, including behavioral health care topics. DMAS participates on the state's Mental Health Planning Council.

Currently, changes to the regulations for mental health community rehabilitation services are being proposed by DMAS. The proposed changes are the result of recommendations of a workgroup convened by DMAS in FY 2001. The workgroup included Department and DMAS staff, CSB and private provider representatives, and individual and family advocates. This group achieved consensus on numerous substantive changes to the regulations and provider manual that should make the services more accessible, flexible, and appropriate for Medicaid recipients. The recommended changes to the provider manual have been implemented. Public comment on the proposed regulations has been analyzed, some revisions have been made and the final proposed regulations are anticipated to be available by December 2003. While these changes did not increase the number of services that are part of the benefit package, the resulting changes were responsive to the concerns and issues identified by the workgroup.

The Report of the President's New Freedom Commission on Mental Health indicates that states have relied on the Medicaid program to support their mental health systems and, as a result, Medicaid is now the largest payer of mental health services in the country. Even with this increased reliance on Medicaid funding, the New Freedom Commission Report suggests that the states have missed opportunities to use Medicaid funding because of uncertainties about:

- How to cover evidence-based practices,
- Which services may be covered under the traditional State Medical Assistance plan,
- Which services are allowable under waiver, and
- How to use Medicaid funds seamlessly with other private sources. (pages 21-22).

Virginia has not taken advantage of opportunities used by many other states to expand critically needed services that could be covered under Medicaid. Although Virginia has increased the number of covered mental health and mental retardation services and has added a limited number of substance abuse services since the program's inception, Medicaid coverage could be expanded for certain mental health services that are either currently supported in large part with state general funds or are provided at a higher cost in state mental health facilities. Many opportunities still exist for DMAS and the Department to improve Medicaid benefits for people with mental disabilities. While service and eligibility improvements for this population may increase costs for DMAS, overall there would be opportunities for state savings through

increased federal participation. The two agencies should develop a joint approach to improving care and supporting the expansion of the community-based service system. Three potential areas to expand Medicaid coverage follow.

- *Programs of Assertive Treatment (PACT) teams*, which provide intensive treatment, rehabilitation, and support services that reduce state hospital utilization. A number of states cover PACT teams in their State Medical Assistance Plans as a discrete service and CMS recently sent a letter to all State Medicaid directors encouraging them to consider this option. As these teams are implemented, additional state savings would be realized through reduced state hospital utilization. Virginia's experience with the existing PACT teams documents significant decreases in state facility bed utilization.
- *Gero-psychiatric Residential Services*, which provide specialized, post-acute psychiatric care for elderly individuals and adults with serious mental illnesses. Currently, these individuals remain in state hospitals even after they are stabilized because they require a level of services that is beyond the capacity of nursing homes to provide. As these specialized programs are implemented, state savings would be realized through reduced state hospital utilization.
- *Peer Support Services*, which would enable individuals with mental illness to counsel other people with similar disorders. The National Governor's Association Center for Best Practices, "*Strategies States Can Use To Employ Persons with Mental Illness",* July 2003 Issue Brief, points out that states can successfully incorporate peer support services in their Medicaid plans under the state rehabilitation option. Trained peer specialists could, for example, help individuals with mental illness handle anxieties associated with choosing, finding, and keeping a job.

Also, DMAS could provide additional state general funds for match to increase access to existing Medicaid mental health services for children and adolescents with serious emotional disturbance, particularly intensive in-home services, residential treatment services, treatment foster care, and acute psychiatric services. In-home services are designed to prevent family crises by providing crisis treatment, individual and family counseling, case management, and 24-hour per day emergency response. Residential treatment services and treatment foster care prevent hospitalization by providing the least restrictive treatment within a small group or family setting. Consideration might also be given to potential future Medicaid service expansion for this population in areas such as crisis stabilization, respite care, family support, and case management.

The Department and DMAS need to work closely together to explore additional ways to maximize opportunities to realize cost savings to the Commonwealth by expanding Medicaid funding for community mental health, mental retardation, and substance abuse services. In order to maximize the amount of federal funds received by the state through the Medicaid program, DMAS embarked on a Revenue Maximization project in FY 2003. During that fiscal year, DMAS, in collaboration with CSBs and the Department, generated supplemental payments for Medicaid mental health clinic services in the amount of $1,017,380. In FY 2004, DMAS intends to repeat this transaction for clinic services. DMAS also proposes additional initiatives to generate supplemental payments for other services provided by CSBs. These services include targeted mental health and mental retardation case management, expanded clinic services (e.g., therapeutic day treatment, day treatment/partial hospitalization, psychosocial rehabilitation, and substance abuse residential treatment and day treatment services for pregnant women), and MR Waiver services.

Both departments need to give priority attention to developing a plan and seeking funding necessary for the phased introduction of new MR Waiver slots in order to respond to the service needs of individuals who are currently on the Waiver waiting lists for services. Successful implementation of the MR Waiver and expansion of MR Waiver slots depends upon the availability of willing services providers. Community providers are finding that current Medicaid

reimbursement rates are not adequate to meet their capital and labor costs. These providers are finding it increasingly difficult to recruit and retain qualified staff. The Department and DMAS need to work together to ensure that current Medicaid reimbursement rates for MR Waiver and State Plan Option services reflect the actual costs of doing business.

Given the importance of Medicaid as a primary source of funding for mental health and mental retardation services, any changes in how the program is structured could have a profound effect on Virginia's mental health and mental retardation services system. Medicaid is by far the largest single source of funds for community services across the state. In FY 2003, out of $628 million of total budgeted revenues, Medicaid reimbursement (all services) is budgeted at $237 million, or almost 38 percent of the total.

The Federal Secretary of Health and Human Services announced a proposal to reform Medicaid by effectively creating a block grant on January 13, 2003. This proposal would do away with Medicaid and SCHIP (State Children's Health Insurance Program), as they currently exist. The proposal offers states the incentive of greater flexibility and additional federal funding, but only if they agree to accept capped allotments. Participating states would receive an additional $3.25 billion in FY 2004 and a total of $12.7 billion over seven years. However, since the Administration has said the proposal will be budget neutral for the federal government over its ten-year time frame, it would appear that the participating states would have to absorb complete reductions in these additional funds during the last three years of the proposed program.

The proposal would merge the four current Medicaid federal funding streams - Medicaid services, SCHIP, Disproportionate Share Hospitals (DSH), and payments for administrative and management expenses - into two streams: acute care and long term care. States would receive capped allotments for acute care and for long term care, and they would be able to transfer up to 10 percent of the funds between the two allotments. States could use up to 15 percent of the funds for administrative and management expenses. The proposal would preserve current mandatory benefits for mandatory groups. Mandatory services are physician services, laboratory and x-ray services, inpatient hospital services, outpatient hospital services, federally qualified health center and rural health clinic services, EPSDT, nursing facility services for individuals over age 21, family planning services and supplies, pregnancy-related services, nurse midwife services, certified nurse practitioner services, and home health care services (for individuals entitled to nursing facility care

Many individual, advocacy, and provider organizations in Virginia's public mental health, mental retardation, and substance abuse services system already have expressed deep concerns about the federal Medicaid Reform proposal. Some of these concerns are listed below.

- *Capped Allotments:* The capped allotments would prevent Medicaid from responding to the ebbs and flows of the economy and health care costs. Medicaid is a counter-cyclical program; as the economy weakens, demand for the program grows. In those situations, capped allotments could shift the increasing demand for health care by uninsured individuals to the state, without the assistance now provided by the federal government through increased federal financial participation, when Medicaid costs increase in response to this phenomenon.
- *Maintenance of Effort (MOE):* States taking capped allotments would have a maintenance of effort requirement. They would have to continue to spend at least the same amount on Medicaid/SCHIP as they do in FY 2002. Also, the MOE requirement will increase annually by a trend rate. Thus, far from increasing flexibility and containing costs, this requirement could decrease the state's flexibility and increase its costs over time.
- *Loss of Entitlements:* Under the guise of increased state flexibility, capped allotments would eliminate the entitlement to health care that now exists in Medicaid. Currently, certain Medicaid recipients have a right to obtain needed services in a timely manner, and the federal and state governments pay for those services.

- *Disproportionate Share Hospitals:* Currently, hospitals that serve a disproportionate share of Medicaid and uninsured patients are eligible to receive supplemental Medicaid payments through the DSH program. DSH payments were designed to provide a designated funding stream to these hospitals, which serve as safety net providers. Nationally, more than 10 percent of all Medicaid funding is through DSH, totally more than $15.8 billion in 2001. This proposal would eliminate designated DSH funding. Hospitals would have to compete with all other providers to receive payments from the acute and long-term care allotments. This could result in a substantial loss of needed revenue at some state mental health facilities, which could increase the demand on state general funds to replace the lost DSH payments.
- *Optional Services:* Nationally, 66 percent of spending on Medicaid services reimburses optional services, which are used particularly by people with disabilities and the elderly. States that take the block grant would have carte blanche to design different benefit packages and eligibility criteria. A state could have different eligibility levels for different geographic areas in the state. Different benefits could be offered to different populations. For optional populations and services, the proposal would eliminate current Medicaid requirements that benefits be comparable among recipients and of sufficient amount, duration, and scope to serve their intended purpose.

Capping allotments to the states, eliminating entitlements to services, virtually abolishing DSH payments, and undermining the state's ability to offer optional services, if enacted, could potentially destroy Virginia's public system of care for individuals with mental illnesses and, especially, for individuals with mental retardation. Virtually all Medicaid funded services for these individuals, except geriatric services in state hospitals, would become optional rather than mandatory services under the proposed initiative. With the severe fiscal dislocations that could occur with implementation of the current proposal (e.g., intense competition among optional services and populations for increasingly scarce dollars), it is conceivable that Medicaid funding for all community services, as well as state MR training centers, could be lost. This would place a tremendous demand on state general funds to replace those lost Medicaid funds or result in decimating the public services system, if those lost funds were not replaced.

Given the evolution of Medicaid SPO and MR Waiver services over the last 12 years, the changing roles of the Department and DMAS during that period, and potential changes in the Medicaid program at the federal level, the Department and DMAS should review the current Memorandum of Agreement (MOA) and develop a new MOA to reflect these circumstances. The Department and DMAS should involve the CSBs, consumers and family members, advocates, and private providers in this process. This new MOA should reflect a prominent role for the Department, as the state authority for public mental health, mental retardation, and substance abuse services, in the development and implementation of Medicaid regulations and policies that affect the services system and in the administration of SPO and MR Waiver services.

Social Services

The *Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996* brought profound changes to federal welfare policy making welfare assistance temporary and employment the goal. At the national level, substance abuse and dependence were recognized as major barriers to obtaining and maintaining employment among "hard-to-employ" Temporary Assistance to Needy Families (TANF) recipients. As part of welfare reform, states have been strongly encouraged to develop comprehensive and innovative approaches to providing substance abuse services for their TANF recipients through partnerships with other agencies and the flexible use of federal and state funds.

The Department's Office of Substance Abuse Services has entered into an agreement with the DSS and DRS to provide services that promote the long term well-being and employment needs of "hard to employ" TANF recipients with an identified substance abuse problem or mental health disability. Three CSBs (Richmond Behavioral Health Authority, Blue Ridge Behavioral

Health and Norfolk CSB) were selected through a competitive process to provide family-centered, community-based substance abuse assessment and referral services and linkages to employment services on-site at their local departments of social service. The specific strategies of this project are to:

- Identify TANF recipients with substance abuse or mental health problems;
- Promote treatment and recovery services, along with specialized employment services, for TANF recipients;
- Provide wraparound support services to individuals and their families;
- Facilitate access to substance abuse and mental health treatment and services through creative linkages and partnerships; and
- Combine welfare reform's "work first" strategy with the flexible use of policy to support substance abuse treatment.

Passage of the federal Adoption and Safe Families Act (ASFA) in 1997 also provided opportunities for collaboration between DSS and OSAS. ASFA places time limits on local departments of social services to resolve custody issues regarding children who have been removed from their families due to abuse or neglect. In many cases, parental substance use is involved. In conjunction with DSS and the State Supreme Court, the Department applied for and received a one-year technical assistance grant from the federal National Center for Substance Abuse and Child Welfare (NCSACW) in 2003. NCSACW is a newly formed center jointly operated by the federal Substance Abuse and Mental Health Services Administration and the Administration on Children, Youth and Families. One of only four states to receive an award, Virginia will receive assistance with developing an interagency strategic plan and a memorandum of understanding to address child safety, permanency planning when the child has been removed, family substance abuse recovery, and other needs for substance affected families involved with the child welfare system and the courts. The Executive Steering and Advisory team includes state and local representation from the Department, DSS, and the state courts system, as well as representatives from the Department of Health, Department of Medical Assistance Services, the Virginia Council on Indians, individuals receiving services, the medical community, and the three currently operating family courts.

The Department's Office of Mental Retardation Services also works with DSS on the development of public policy affecting people with mental retardation, and most recently participated in the development of the new Adult Protective Services regulations.

Housing

In an ongoing effort to promote, enhance, and develop housing opportunities for individuals receiving mental health and substance abuse services, the Department has maintained collaborative linkages, partnerships and activities with VHDA, DHCD, the Disability Commission's Housing Workgroup, the Virginia Interagency Action Council on Homelessness (VIACH), the Virginia Housing Study Commission, CSBs, and public and private housing providers.

The primary barrier to the provision of housing for adults with mental disabilities is affordability. According to *Priced Out in 2002,* people receiving SSI benefits in Virginia had incomes equal to only 14.6 percent of the median one-person household income in 2002. Even in the lowest income areas of the state, SSI is below 22 percent of the median income. According to a report published by the National Low Income Housing Coalition, the average person living in Virginia needs over three times the SSI benefit to afford a modest one-bedroom apartment at HUD's Fair Market Rent (FMR). FMRs are based on the cost of modest rental housing and are calculated annually by HUD for use in the Section 8 Housing Choice Voucher program. A housing unit at the Fair Market Rent is meant to be modest, not luxurious, costing less than the typical unit of that bedroom size in that city or county.

The gap between the cost of housing and the incomes of disabled Virginians is increasing. Between 2000 and 2002, rents of modest one-bedroom housing units throughout Virginia increased an average of 18 percent, but SSI benefit levels rose only 6 percent. The proposed FY 2004 FMR for a one-bedroom unit ranges from a low of $389 in the southern and western Virginia to a high of $1,039 per month in northern Virginia. Affordable housing is generally defined as housing costs that are at or below 30 percent of monthly income. However for people on SSI, who receive $545 per month, one-bedroom units at FMR will cost between 71 percent and 191 percent of their monthly income in Virginia.

The *Analysis of Housing Needs in the Commonwealth* (Virginia Department of Housing and Community Development and the Virginia Housing Development Authority, November 2001) reports that "demand for affordable housing among people with disabilities will continue to increase rapidly due to a number of factors including: the unresolved need to provide community living alternatives to institutional placement, the continued increase in life expectancy among disabled people, and the advanced age of many family care givers… [Yet,] the declining ratio of deep rental subsidy units to renter households in metropolitan housing markets will pose a severe challenge to addressing the needs of disabled people, particularly given the extremely large gap between prevailing rents and the incomes of most disabled people…"

This lack of affordable housing has been cited as the primary cause of homelessness among people with disabilities. Poor people who have a mental disability are at increased risk for homelessness. The number of Virginians with serious mental illnesses estimated to be homeless each year is between 12,000 and 20,000. This is based on studies that project between 5 percent (Task Force on Homelessness, 1992) and 8.4 percent (Culhane, 1997) of adults with serious mental illness become homeless each year. This population is often disengaged from mental health services and in great need of housing and support services.

The Virginia Department of Housing and Community Development (DHCD) reports in its Draft FY 2004 Consolidated Plan, however, that homeless people with mental illness make up only "eight percent of adults sheltered, while four percent of adult clients served had been deinstitutionalized immediately before entering a shelter… These figures are well below national estimates that indicate that the mentally ill homeless comprise up to 33 percent of the homeless population. The reasons for this divergence from national estimates are not clear. It is possible the shelters surveyed do not generally serve this particular subpopulation, and that shelter staffs often are not qualified or able to make mental health diagnoses. Therefore, it is likely that a large percentage of the mentally ill homeless remain unsheltered, or that the needs of those sheltered are not entirely addressed."

The Department administers the federal Projects for Assistance in Transition from Homelessness (PATH) formula grant program, which funds outreach and engagement services for persons who are homeless and have serious mental illness across the state. PATH has provided funds each year since 1991 for essential services to homeless people who have serious mental illness and those with co-occurring substance abuse disorders. These funds are utilized by eighteen organizations (sixteen CSBs and two non-profits) to provide outreach, assessment, case management, and linkages to mental health services and housing.

In FY 2002, these organizations provided outreach to 6,988 homeless persons and 2,324 (33 percent) of them were enrolled in PATH services. At enrollment, most (62 percent) were unengaged with the mental health system and without any shelter (68 percent). PATH-funded staff helped 1,035 get into shelters and 828 were helped with housing assistance applications, 460 were placed in housing, and 852 were placed in mental health services. States are required to match PATH funds with cash or in-kind resources at a minimum of 33 percent, but Virginia's local providers have always contributed more than that amount to this much-needed program. While some housing services, such as one-time rental assistance and help in locating

housing, are eligible PATH expenses, the focus of PATH services continues to be on outreach and engagement with mental health services.

The Department contracts with Oxford House, Inc. to provide loan management and technical assistance to Oxford Houses in Virginia. Oxford House, Inc., is a network of self-run, self-supported recovery houses located in Virginia and in other states. Oxford House, Inc. fosters democratically-run group housing where individuals are able to live a clean and sober lifestyle in a safe and affordable environment. When an individual is accepted into the house, there is no time limit on how long he or she can live there, but use of alcohol or drugs or non-payment of rent will result in expulsion. Presently there are 54 Oxford Houses in Virginia; 39 houses for men, 13 houses for women, and 2 houses for women with children. The expectation is that the Commonwealth will continue to contract with Oxford House, Inc. or another contractor to continue providing housing for persons in recovery, statewide.

While there is a recognized and growing need for intensive and supervised housing options, most mental health individuals prefer the supportive housing model rather than intensive or supervised residential services. These individuals are able and prefer to live independently in existing community housing, provided that they are able to readily access an array of community-based services. Individuals with disabilities often cannot locate housing that is available, affordable, accessible, and appropriately situated with respect to the availability of supportive services. Too often, housing is contingent on and rigidly linked to supportive services (as in the Assisted Living Facility model) or, conversely is located where necessary services are unavailable or relatively inaccessible.

A recent study (Culhane et al, 2002) on the impact of supportive housing programs for persons who were homeless and had serious mental illness revealed that those placed in supportive housing programs experience marked reductions in shelter use, hospitalizations, length of stay when re-hospitalized, and incarceration. This research demonstrates that, for this study group, the costs of providing supportive housing are nearly made up in reductions in expenditures for providing care in homeless shelters, acute psychiatric and medical services, and the public costs of incarceration.

These conclusions are consistent with results of a Department study of Virginia's PACT program, which found that PACT individuals with housing stability (i.e., living in only one or two places during the year and having no episodes of homelessness) were 8.6 times more likely to have few or no hospitalizations (controlling for age, racial status, gender, substance abuse diagnosis, pre-PACT state hospital admissions, and team staffing fidelity levels).

The success of the Department's Reinvestment and Regional Restructuring Partnership planning initiatives will be dependent in part upon the availability of affordable housing options for persons transitioning from institutional care and those struggling to maintain stable housing in the community. The Department has the opportunity to collaborate with DHCD, VHDA, and other public entities in developing and implementing the following three affordable housing development plans for the benefit of low-income Virginians with mental disabilities.

DHCD's Consolidated Plan proposes to develop a comprehensive ten-year plan to end homelessness that includes a strategy for housing chronically homeless adults by developing a program for providing tenant-based rental assistance using federal HOME funds. It plans to contract with two community-based programs to provide tenant based rental assistance to 40 chronically homeless adults by 2008. DHCD also anticipates the use of approximately $15,000,000 in revenue from the sale of the Virginia Housing Partnerships Fund (VHPF) as mandated by the 2003 session of the Virginia General Assembly. Funds obtained from the sale of the VHPF will constitute a new fund that will serve primarily as a resource for predevelopment expenses and special needs projects, some of which should be targeted to Virginians with mental disabilities.

The Olmstead Task Force Report highlights the critical importance of assuring the availability of adequate supplies of affordable housing in order to assure that persons with disabilities live as independently as possible in the communities of their choice. The Task Force found that a wide range of community housing stock and models of support are not available because of a lack of adequate subsidies and other factors, and that State agencies must work collaboratively and creatively to make housing available and affordable for Virginians with disabilities under the Olmstead decision.

The Disability Commission has also focused on the housing needs of people with disabilities in its creation of a Disability Housing Workgroup (including representation by the Department and CSBs) to work with DHCD in developing a Housing Action Plan. Subsequently, a report entitled "Expansion of Affordable, Accessible Housing For Persons With Disabilities And Frail Elders Statewide" was prepared by the National Disability Institute and the Technical Assistance Collaborative and reviewed by the workgroup.

With over 4,500 individuals with mental retardation living in the community in a variety of living arrangements, very few own their own home or condominium. In 2000, Fannie Mae and a newly created Home of Your Own Alliance worked cooperatively with mortgage companies and persons with disabilities who wished to own their own homes. This effort may provide an opportunity for individuals with cognitive disabilities in Virginia who wish to pursue home ownership.

Primary Health Care

There are now a number of published studies that show that people with serious mental illness have higher rates of physical disability, significantly poorer health, and higher mortality rates than the general population. This is due in part to low income, a lack of health insurance, and the lack of access to adequate primary health care. The Virginia Primary Care Association (VPCA) defines access as the opportunity to receive the services of general practice physicians (family practice, internal medicine, pediatricians) or other primary care providers, such as nurse practitioners or physician's assistants, and services such as lab tests, x-rays, and medications.

Although the relationship between mental illness, physical health and disability, and poverty are not clearly understood, research shows that poverty and the lack of access to primary health care are significant factors in both poor health and mental illness. (Mauksch et al, 2001) The picture is further complicated by the lack of understanding of the special needs of this population among many primary care physicians. Such needs may include spending more time with the person to help him understand the treatment regime, enlisting the help of a family member or friend of the patient, referrals to social service agencies to provide for transportation for clinic visits, and referrals to nutritionists and other specialists to improve the person's health behaviors. This inability to recognize the special needs of persons with serious mental illness may lead to further impairments, increased use of medical services, and higher costs. (Golomb, et al, 2000)

The literature shows that when persons with mental illness are given choices about the service delivery models they prefer, they consistently choose a model that provides for ongoing collaborative care between primary care and mental health providers. Collaborative care includes the following key elements. (White, 1997)

- Close proximity between the primary care physician and the mental health provider is critical to improved care. Close proximity, even one day a week, allows practitioners to communicate and integrate their care strategies, and it reduces the transportation burden that creates barriers to access for many people with mental illness.
- Establishing relationships between primary care physicians and mental health providers is key to fostering collaborative working relationships. Referrals and ongoing communication are more likely to occur among providers who know each other and have established a positive working relationship. Service systems and physician leaders can promote such

relationships through professional organizations, by sponsoring training programs that are of interest to both groups, and by creating opportunities that facilitate such relationships, for example through joint faculty appointments and psychiatric residency placements for medical students.

- Sharing records, with the consent of individuals receiving treatment, facilitates collaboration. When primary care physicians and psychiatrists both have access to records, there can be more consistency in treatment. This, of course, is facilitated when both practitioners are located in close proximity to each other, preferably in the same building.

In many areas of Virginia, the most significant barrier to primary health care is the lack of providers in the individual's community. The VPCA is devoted to improving access to primary care by increasing the number of practitioners in underserved areas of the state. One of their goals is to provide primary care to uninsured Virginians within a reasonable travel distance. They do so through their Scepter program, which places medical students and other primary health care professional students in Community Health Centers for two to six week rotations; through organized recruitment efforts; and by working with communities to develop solutions for improving access.

Accessing primary health care is a problem for people with mental retardation of all ages as evidenced by the Surgeon General's recent efforts to promote study of and develop action steps in response to this issue. Some access issues involve the inability of people with mental retardation to communicate pain, symptoms or emotions through verbal channels, only through behaviors. Primary care medical practitioners are not educated in how to understand or treat people who cannot articulate symptoms or the source of their pain or illness. As the likelihood of physical and cognitive complications increase with age, the need for primary care practitioners will increase equally. They may require the assistance of professionals in the field of mental retardation to help them distinguish between challenging behaviors that are the individual's only means of communicating pain or dissatisfaction versus a manifestation of psychosis.

According to a May 2000 (Columbia University, National Center on Addiction and Substance Abuse-CASA) survey of primary care providers and physicians, nine out of ten (94 percent) primary care physicians fail to diagnose substance abuse when presented with symptoms of alcohol abuse in an adult patient, and 41 percent of pediatricians fail to diagnose illegal drug abuse when presented with a classic description of a drug abusing teenage patient. The survey revealed that physicians are missing or misdiagnosing a patient's substance abuse for several reasons: lack of adequate training in medical school, residency, or continuing medical education courses; skepticism about treatment effectiveness; discomfort discussing substance abuse; time constraints; and patient resistance.

The study also revealed that physicians feel unprepared to diagnose substance abuse and lack confidence in the effectiveness of treatment. Only a small percentage of responding physicians consider themselves to be "very prepared" to diagnose alcoholism (19.9 percent), illegal drug use (16.9 percent) or prescription drug abuse (30.2 percent); whereas they feel "very prepared" to identify hypertension (82.8 percent), diabetes (82.3 percent), and depression (44.1 percent).

Since substance use disorders are often chronic conditions that progress slowly over time, primary care clinicians (physicians, physician assistants, and advanced practice nurses), through their regular, long-term contact with patients, are in an ideal position to screen for alcohol and drug problems and monitor each patient's status. (SAMHSA-CSAT Treatment Improvement Protocol #24) Furthermore, studies have found that primary care clinicians can actually help many patients decrease alcohol consumption and its harmful consequences through office-based interventions that take only 10 or 15 minutes. (Kahan et al., 1995; Wallace et al., 1988)

Even though screening and limited treatment of substance use disorders do not require a large time investment, primary care clinicians are already overwhelmed by the demands of their clinical practice, and a practical approach is needed: one that recognizes the time and resource limitations inherent in primary care practice and that offers a series of graduated approaches that can be incorporated into a normal clinic or office routine. (SAMHSA-CSAT Treatment Improvement Protocol #24)

In 2000, the Department participated in a regional summit co-sponsored by the U.S. Substance Abuse and Mental Health Services Administration and the Health Resource and Services Administration, Bureau of Primary Health Care, National Health Service Corps that focused on "Ensuring the Supply of Mental and Behavioral Health Services and Providers." Out of this summit, individual and cross-state action plans were developed. As a result of attending the summit, the Department entered into a partnership with VDH, VPCA, and the Virginia Rural Health Resource Center (VRHRC). The Partnership sponsored a two-day conference in September 2002 that focused on integrating behavioral health into primary care. The OSAS, working closely with the VPCA and the VRHRC, also developed a Toolbox of brief screening tool, and referral information for distribution to primary health care providers. VPCA distributed the Toolbox to its membership at its most recent annual meeting, and recently received funds from the U.S. Center for Substance Abuse Treatment to produce and distribute additional Toolboxes. The Toolbox will be regularly revised to include information about specific populations and to reflect advances in research.

In addition, the Department met in October 2003 with officials of the Virginia Association of Free Clinics (VAFC) in order to open a dialogue about areas of mutual interest. According to a survey conducted by the VAFC in September 2003, approximately 250 persons per week are seeking access to mental health services through Virginia's Free Clinics because services are not available from CSBs. These individuals most often need medications and outpatient counseling. Department staff and CSB physicians also participated with the Medical Directors and staff of Virginia's Free Clinics in a continuing medical education program sponsored by the Medical Society of Virginia which focused on delivering mental health care to the medically underserved.

The Department's OSAS also continues to work closely with the VDH and DSS to identify and provide services to pregnant, parenting, and at-risk women. Ten CSBs operate Project Link, a collaborative project that reduces barriers to pregnant women needing substance abuse services by providing "no wrong door" services, childcare, transportation, and case management, as well as linkages with local hospital delivery rooms. In 2002, OSAS worked closely with VDH to assess HIV and substance use screening practices employed by obstetricians and hospitals. Using this information, DSS developed an educational brochure providing screening protocol guidance.

Employment Services and Supports

Adults with a serious mental illness and youth with serious emotional disturbances face challenging obstacles to obtaining and maintaining competitive employment. These include interruptions in education and employment that may be caused by symptom onset and exacerbation, pervasive stigma, and the limited availability of the evidence based practice of supported employment for these populations. These obstacles, coupled with a fear of losing health insurance coverage, the most often cited obstacle to employment by individuals on SSDI or SSI, especially coverage for prescription drugs, and the lack of accurate information about current complex work incentives for individuals, case managers, and service providers all combine to form significant barriers to improving individuals' self-sufficiency and independence. Complicated funding streams and varied and frequently uncoordinated vocational assistance programs and approaches taken by multiple agencies add to the difficulties individuals, staff, and providers encounter when addressing employment-related concerns.

The Department intends to address many of these barriers through continuing and broadening its collaboration and coordination with multiple federal and state agencies, entities of local government, universities, public and private providers, individuals, family members, and advocacy groups through implementation of several diverse but coordinated initiatives.

Joint mental health and substance abuse employment initiatives between the Department and DRS focus on specialized vocational assistance services in CSB mental health and substance abuse programs and a provider training program for individuals receiving mental health services. These programs are intended to bring about greater community integration and vocational success. Vocational assistance services should include, but not be restricted to, job placement and follow-up services; vocational training and education, as appropriate; physical and psychological examinations; maintenance and transportation assistance; interpreter and note-taking services, when needed; telecommunication, sensory, and other technological aids and devices; occupational licenses, tools, equipment, stocks, and supplies, as appropriate; and supported employment services to assist in job placement, job site training, and follow-through.

- Because employment is a major motivator and stabilizer for persons in recovery from substance use disorders, the Department maintains an interagency agreement with the DRS that funds 21 DRS counselors who provide co-located clinical and employment-oriented programs that address employment and community stability through vocational development, work habits, job readiness, and employment follow-along services, along with coordinated CSB clinical and social supports.
- DRS counselors in 11 CSBs provide employment services for individuals receiving mental health services. These counselors are placed within CSB psychosocial rehabilitation or community support programs and provide individuals who want to work with job development, placement, and retention services.
- Collaboration among DRS, the Department, Piedmont Virginia Community College, and the Region Ten CSB established and continues to support the Virginia Human Services Training Center (VHST). VHST is a training program that offers adults living with serious mental illnesses an opportunity to be trained to work in the field of mental health.

Additionally, the Department's Office of Mental Retardation Services works with DRS through an interagency agreement to provide specialized services to nursing home residents with developmental disabilities. The two agencies meet regularly to review the issues and progress related to delivery of those services. The Office also participates as a member of the Employment Services Organization, a work group made up of public and private vendors offering supported employment and workshop services.

The *Ticket to Work and Work Incentives Improvement Act of 1999* (TWWIIA) and the President's subsequent New Freedom Initiative created a host of new grant opportunities for states to improve employment outcomes for people with disabilities. The Department has collaborated with DRS, DMAS, and multiple other entities on a variety of grant application initiatives.

- In FFY 2002 DMAS was awarded up to $500,000 for *Virginia's Infrastructure Grant Proposal.* Activities have included designing, implementing, and testing the impact of Medicaid Buy-In options and improving the utilization of existing work incentives available through various Social Security Administration programs. The Medicaid Infrastructure Grant has continued and the 2003 General Assembly directed DMAS to seek a research and demonstration waiver pursuant to §1115 of the Social Security Act from the Centers for Medicaid and Medicare Services to establish a Medicaid Buy-In Program. The Medicaid Buy-In Committee is currently in the process of developing this proposal.
- In FY 2003, DRS, in conjunction with the Department, as convener of Virginia's Olmstead Task Force, submitted a successful WorkFORCE Coordinating Grant Application to the Department of Labor for up to $150,000 for one year. Grant funds are being utilized to support the customization of WorkWORLD™ decision support computer software for

Virginia through the Virginia Commonwealth University School of Business' Employment Support Institute and to provide staff support to the employment-related component of the Olmstead Task Force. WorkWORLD™ is software that is designed to support people with disabilities making critical decisions about gainful work activity and the use of work incentives. WorkWORLD™ software allows individual receiving services to learn about how policies and "What If?" scenarios can affect their income and access to health care. Simultaneously, state agencies, disability services providers, and other relevant entities are engaging in strategic statewide coordination, planning, and development of the software that will lead to improved opportunities for competitive employment for people with disabilities. For example, the Medicaid Buy-In Committee is using the software to examine the impact of current and proposed policies on its waiver proposal.

- In FY 2003 the Department collaborated with numerous entities to support Workforce Investment Board (WIB) grant applications to the U.S. Department of Labor. The Northern Virginia Workforce Investment Board was awarded approximately $600,000 for one year (five year renewable grant) for *Project One Source*. Funds are being utilized to enhance the Northern Virginia One-Stop's capacity to provide coordinated, seamless employment services to adults with disabilities and to ensure a well-trained staff in the One-Stop Centers. In addition, Department staff serves on the Executive Management Council of the project awarded to the Capitol Area Workforce Investment Board (Capitol Area Training Consortium). The Capitol Area WIB was awarded approximately $975,000 for 24 months to enhance the ability of Virginia's One-Stop service delivery system to provide comprehensive employment services to jobseekers with disabilities and to enhance physical and program accessibility of the One-Stop system.
- In June 2003, the Department collaborated with over 35 state, county, and community partners in the development of a $600,000 grant application submitted by the Virginia Association of Community Rehabilitation Programs (vaACCSES), entitled *One Community* WorkFORCE, to the Department of Labor Office of Disability Employment Policy. If funded, the project offers the mental health and brain injury services systems a comprehensive approach to reduce barriers and provide solutions for increased participation and effective employment outcomes for people with psychiatric disabilities and persons with brain injury. The *One Community* WorkFORCE project, which the Governor has indicated would be an official demonstration of the state's Olmstead employment plans for people with disabilities, introduces initiatives to promote systems change and demonstration strategies that are designed to increase the transition of individuals from institutions into the community and workplace. The NVMHI will serve as one of the pilot sites.
- Currently (September 2003), the Department is collaborating with DRS and other agencies and entities in the Northern Virginia area to apply for funding from the federal Office of Special Education and Rehabilitative Services for a model demonstration project focused on mentoring for transition-age youth and young adults with disabilities. The proposed project would test whether DRS can achieve increases in meaningful postsecondary education and quality employment outcomes through the use of mentors.

Criminal Justice Services

In 2001, the *Code of Virginia* was amended to establish the Interagency Drug Offender Committee, jointly chaired by the Secretary of Public Safety and the Secretary of Health and Human Resources (§ 2.2-233). This Committee includes representatives of the Department, DOC, DCJS, DJJ, the Commission on Alcohol Safety Action Programs, the Supreme Court, and the Virginia Criminal Sentencing Commission. The purpose of the Committee is to oversee the development of substance abuse screening, assessment, and treatment protocols to be administered to young, first offenders subject to new sentencing options that allowed judicial discretion to waive traditional sanctions and sentence the offender to substance abuse treatment, including participation in drug courts where they exist. Although funds to support

services ended with the elimination of the Substance Abuse Rehabilitation and Education program, the Committee did develop policies and procedures for screening, assessment, and treatment and developed a model memorandum of agreement for CSBs to utilize with local criminal justice agencies. Drug courts, operating in limited areas of Virginia, may assume responsibility for screening, assessment, and referral.

Interagency Councils and Partnerships

Virginia Board for People with Disabilities – The Department is a member of this Board, which is the state's Developmental Disabilities Council and is responsible for reporting to the Governor on a variety of disability issues. The Board awards federal funds for grant projects, such as the Development of Positive Behavioral Support Techniques, a grant in which the Department's Office of Mental Retardation Services participates. The Board also funds ongoing programs such as the Youth Leadership Forum and Partners in Policy Making, both designed to prepare individuals and families to understand disability services systems and become advocates.

Commission on Youth – The Department actively participates on legislative study committees of the Commission on Youth. In the past year the Commission disseminated the *Collection of Evidence Based Treatment Modalities for Children and Adolescents with Mental Health Treatment Needs*. This document is being electronically disseminated across Virginia to families and public and private providers to increase utilization of evidence based services and practices in child and adolescent mental health treatments. This document may be accessed through www.coy.state.va.us.

Comprehensive Services Act (CSA) – The DMHMRSAS Commissioner is a member of the State Executive Council, which meets monthly and sets policy for community services provided pursuant to the Comprehensive Services Act for At Risk Youth and Families (CSA). Department staff are active participants in the State and Local Advisory Team, which is charged in the *Code of Virginia* §2.1-747 with advising the State Executive Council on state and local CSA operations and service delivery. The Department and other state agency participants provide administrative support for the team in the development and implementation of the collaborative system of services and funding authorized under the CSA. This Team meets monthly. A second CSA team, the Training and Technical Assistance Team, assists local and regional communities in planning and developing training to meet the needs of children and families and systemic needs of local agencies. This team meets at least quarterly to determine training needs.

Mental Health Planning Council - This Council, required by P.L. 102-321 as a condition of Community Mental Health Services Block Grant funding, was initially created in 1989. The Council serves as an advocate for adults with serious mental illness and children with serious emotional disturbance and is authorized in P.L. 102-321 to review, monitor, and evaluate the state's mental health system. The Council has 35 members, including mental health individuals, family members, parents of children with serious emotional disturbances, representatives of key state agencies, state mental health facilities, and major mental health advocacy groups. In addition to functioning in an advisory capacity to the Department, the Council guides the Department in developing individual and family education and manages a small budget of $25,000 that is used to support Council activities, including an annual retreat. Each year, the Council prepares an annual report and recommendations to the state, which is submitted to the Center for Mental Health Services as part of the Department's federal block grant application.

Substance Abuse Services Council – This Council, established by the *Code of Virginia*, § 37.1-207, consists of agency directors (or their delegates) representing the Department, VDH, DSS, DOE, DOC, DJJ, DCJS, the Commission on Alcohol Safety Action Programs, four members of the House of Delegates, two members of the Senate, and representatives from key groups engaged in substance abuse issues (i.e., the VACSB, the Substance Abuse Certification Alliance of Virginia, the Virginia Association of Alcoholism and Drug Abuse Counselors the

Virginia Association of Drug and Alcohol Programs the Virginia Sheriff's Association, and the advocacy community). The Council advises and makes recommendations to the Governor, the General Assembly, and the State Board on broad policies and goal and on the coordination of Virginia's public and private efforts to control alcohol and other drug abuse. In preparation for a formal report and interagency plan to be presented to the Governor and the General Assembly, the Council conducted a survey of state agencies and held five of focus groups throughout Virginia to identify critical issues and trends in substance abuse. Critical issues identified include the need for advocacy and education, enhanced collaboration, additional funding, leadership, and service system issues such as access, capacity, continuum of care, and quality of care. This plan will be presented to the Governor and the General Assembly in the Fall of 2003. The Council maintains a website at www.dmhmrsas.state.va.us/sasc/.

Governor's Office for Substance Abuse Prevention (GOSAP) – The Department is actively involved with the Governor's Office for Substance Abuse Prevention (GOSAP), a federal-state initiative funded by the SAMHSA Center for Substance Abuse Prevention. Housed in the Office of the Secretary of Public Safety, GOSAP brings together the Department, VDH, DCJS, DOE, DSS, DJJ, the Department of Motor Vehicles, the Department of Alcoholic Beverage Control, and the Tobacco Settlement Foundation to coordinate Virginia's substance abuse activities for efficient and effective use of resources. GOSAP administers the CSAP State Incentive Grant and the Governor's discretionary portion of the Safe and Drug Free Schools Act grant. GOSAP maintains a website at www.gosap.state.va.us.

Early Intervention (Part C) Interagency Management Team – The Part C Program is an interagency endeavor with an interagency management team as established in *Virginia Code*. This team has representation from the DBVI, DDHH, DSS, VDH, DOE, DMAS, VOPA, and the State Corporation Commission. A representative from the Virginia Association of Community Services Boards also participates with the team. This group guides the program direction in accordance with federal and state policies.

Virginia Advisory Committee on Juvenile Justice – The DCJS Juvenile Services Section, administers three primary juvenile justice federal funding streams allocated to Virginia. In 1994, DCJS implemented a strategy to use these funds along the continuum of juvenile justice, from prevention through community-based interventions to secure confinement. The three funds are: Title V and II of the Juvenile Justice and Delinquency Prevention (JJDP) Act and the Juvenile Accountability Incentive Block Grant (JAIBG) programs. These funds are intended to address the problem of juvenile crime by promoting greater accountability in the juvenile justice system. This Advisory Committee sets priorities for spending, reviews state and local grants, and makes plans to improve juvenile services in Virginia. The Department actively participates in the fall, winter, and spring meetings of the Virginia Advisory Committee on Juvenile Justice. During FY 2002 and FY 2003, the Advisory Committee established mental health services to juvenile offenders as a priority for spending. Many children in Virginia's juvenile justice system have demonstrated mental heath needs. An analysis of juveniles committed to the State's correctional facilities indicated that, in 1998, 47 percent of males and 57 percent of females had identified mental health treatment needs. They also reported a history of substance abuse. (Source: Virginia's Three-Year Plan 2003-2005, Juvenile Justice and Delinquency Prevention Act, the Juvenile Services Section, Department of Criminal Justice Services.) With this priority designation, CSBs and the Department were able to apply for funds to meet the mental health needs of juveniles and juvenile offenders. In July 2003, the Department received a one-year grant award from the DCJS of $549,825 (including a local and state match) to provide a mental health clinician and case manager in five detention centers. Funds were distributed to five CSBs to provide mental health treatment services, psychiatric evaluations and substance abuse services to juvenile offenders in need of these services.

Virginia Intercommunity Transition Council – This Council promotes successful transition outcomes for youth and young adults with disabilities by providing leadership and innovation in planning and developing services across agencies to meet their employment, education,

training, and community services and supports needs. Youth with serious emotional behaviors face many new challenges when they reach young adulthood, including burdens related to seeking employment and advanced education and training and maintaining community life. Far too often, these youth become homeless or unemployed, drop out of school, or end up in the correctional system. In the past year, the Department collaborated with DOE and DRS to provide training to parents, counselors, teachers, and providers to develop and provide comprehensive community-based services to young adults. The VITC will continue to provide technical assistance related to transition planning for these young adults.

Program Improvement Plan Committee of the Child and Family Services Review Task Force – The 1994 Amendments to the Social Security Act authorized the U.S. Department of Health and Human Services to review State child and family services programs in order to ensure substantial conformity with the State plan requirements in titles IV-B and IV-E or the Social Security Act. The reviews cover child protective services, foster care, adoption, family preservation and family support, and independent living. The reviews are designed to help states improve child welfare services and outcomes for families and children who receive services by identifying strengths and needs within state programs, as well as areas where technical assistance can lead to program improvements. To prepare for the federal audit, DSS organized a Task Force of state and local agencies and family organization to conduct a 6-month assessment of the state's programs before the review, determine the sites, and serve as an advisory committee for the development of the Program Improvement Plan after the review. A representative from the Department and the Child and Family Council of the VACSB serve on this Task Force, which meets monthly.

Virginia's review was held during the week of July 7- 11, 2003. The review examined seven outcomes across three domains: safety, permanency, and child and family well being. Virginia's preliminary results indicated nonconformity in meeting the mental health needs of children in child welfare. This outcome failure presents an opportunity for improved services and collaboration between CSBs and local social services departments. The DSS must develop a Program Improvement Plan (PIP) that covers all areas of nonconformity within 90 calendar days of receiving the written notices of nonconformity. During September and October 2003, DSS reviewed the preliminary results with all 130 local social services departments in order to engage their participation in the development of the Improvement Plan. These local departments must conform to the approved PIP. If the State fails to make improvements needed to bring areas of non-conformity into substantial conformity, federal funds are withheld commensurate with the level of the nonconformity. Many of the children in the child welfare system receive services through the CSBs.

Child Fatality Review Team – The Department has continued to serve on the State Child Fatality Review Team, established pursuant to the *Code of Virginia* §32.1-283.1 B. This 16-member Team develops and implements procedures to ensure that child deaths occurring in Virginia are analyzed in a systematic way. Team recommendations are used to develop procedures for the review of child deaths; improve the identification, data collection, and record keeping of the causes of child deaths; recommend components for a prevention and education program; recommend training; improve the investigations for child deaths; and provide technical assistance, upon request, to any local child fatality teams that may be established. Team recommendations are used for public health planning, prevention programming, and policy discussions and recommendations. From 1995 - 2001, the Team reviewed child deaths due to firearms, suicide, and unintentional injury. In December 2002, the Committee completed a report on 2001 child deaths due to unintentional injury, suicide, homicide, and natural or undetermined causes. For 2003-2005, the Team will review child deaths related to vehicular violence. The Team meets bimonthly at the Office of the Medical Examiner.

Commonwealth Partnership for Women and Children Affected by Substance Use – The Partnership's membership consists of representatives from VDH, DOE, DSS, DOC, CSBs and contract providers, local departments of social services and health, local housing authorities, the

Medical College of Virginia, provider associations, the faith community, and local nonprofit agencies, all organizations that provide services for women and children whose lives have been affected by substance use. The Partnership seeks to identify and resolve barriers to services by seeking resources, encouraging interagency collaboration, participating in community planning and policy development, and coordinating education and training events.

Goals, Objectives, and Action Steps

Goal 35: Maintain and strengthen the collegial relationship described and operationalized in the Central Office, State Facility, and Community Services Board Partnership Agreement.

Objective:

1. Reflect and adhere to the values, roles, responsibilities, and tenets of the Partnership Agreement in the Department's leadership and day-to-day management of the public mental health, mental retardation, and substance abuse services system.

Action Steps:

a. Periodically review the provisions of the Agreement with the operational partners to assure the continued relevance and applicability of those provisions.

b. In the forum of the System Leadership Council, examine at least annually the functioning of the services system to assess adherence of the partners to the Agreement and its impact on the system.

c. Solicit input and feedback on a regular basis from the operational partners about ways to enhance and strengthen the Agreement and relationships among the Department's Central Office, CSBs, and state facilities.

Goal 36: Encourage and facilitate greater private provider participation in the public mental health, mental retardation, and substance abuse services system.

Objectives:

1. Identify ways to increase the number of private providers participating in the publicly managed services system and to expand the array of services they offer.

Action Steps:

a. Urge DMAS to study current reimbursement rates for Medicaid State Plan Option and MR Waiver services and adjust them where warranted to encourage greater private sector participation in the publicly funded services system.

b. Work with DMAS to identify and implement strategies for ensuring that Medicaid managed care plans permit the provision of adequate types and amounts of necessary services and reimburse providers for the reasonable costs of delivering services.

c. Work with all affected partners (e.g., CSBs, the Virginia Hospital and Healthcare Association, health planning agencies, individuals, families, and advocacy groups) to identify and implement regional and statewide strategies for ensuring the availability of an adequate number of local acute psychiatric beds and appropriate alternatives that could serve individuals in need of acute psychiatric services in their communities.

d. Continue to work with CSBs and private providers to address workforce issues affecting the availability of adequate numbers of quality staff in community services.

e. Ensure that funding requests contain sufficient provisions for necessary start-up expenses (e.g., staff recruitment and training, equipment purchases, acquisition of space, and operating at less than full capacity during the implementation phase).

Goal 37: Realize cost savings to the Commonwealth by expanding Medicaid funding for community mental health, mental retardation, and substance abuse services.

Objectives:

1. Partner with DMAS to administer MR Waiver and State Plan Option Services.

Action Steps:

a. Jointly review the MOA between the Department and DMAS and develop a new MOA that clarifies and reaffirms the Department's role in policy and operations related to the MR Waiver and State Plan Option services.

b. Work with DMAS to explore additional opportunities to maximize the amount of federal funds received by the Commonwealth through the Medicaid program.

c. Monitor and assess the potential impact of federal efforts to reform Medicaid on Virginia's mental health, mental retardation, and substance abuse services system.

2. Reduce the waiting list for MR Waiver services.

Action Steps:

a. Work with DMAS to jointly develop a multi-year plan and funding strategy for the phased implementation of additional MR Waiver slots to address documented waiting list demand.

b. Support DMAS efforts to seek funding for MR Waiver services.

3. Expand State Plan Option Services covered under the State Medical Assistance Plan.

Action Steps:

a. Work with DMAS to jointly explore opportunities for expanding Medicaid-covered mental health services to include PACT, gero-psychiatric residential services, peer support services, and additional child and adolescent mental health services.

b. Support DMAS efforts to seek funding for State Plan Option Services.

***4.* Implement a broad array of Medicaid covered substance abuse treatment services that would maximize system revenue and adhere to a high standard of care.**

Action Steps:

a. Continue to monitor national trends in utilizing Medicaid as a source of revenue for substance abuse treatment.

b. Continue to monitor policy development at the federal level related to Medicaid eligible populations, services and funding mechanisms.

c. Continue to monitor opportunities to develop Medicaid as a funding source within the Commonwealth's budget structure.

d. Continue to monitor utilization trends for the two substance abuse treatment services currently included in the state's Medical Assistance Plan.

Goal 38: Increase the stability of families affected by mental illnesses and substance use disorders that are receiving TANF benefits or involved in protective services.

Objectives:

***1. Provide mental health and substance abuse services to families involved in TANF, ASFA, or other social services initiatives*.**

Action Steps:

a. Improve assessment strategies.

b. Improve matching of individual needs to service type, intensity, and length of treatment.
c. Expand opportunities for cross-training and other methods of technology transfer.
d. Utilize resources made available through the grant from the National Center for Substance Abuse and Child Welfare to solidify planning and collaboration.

Goal 39: Expand safe and affordable housing alternatives that meet the needs of individuals receiving mental health, mental retardation, and substance abuse services.

Objectives:

1. Pursue funding resources and interagency collaborative responses to meet housing needs.

Action Steps:

a. Provide ongoing assistance to CSBs and publicly funded services providers in accessing federal resources to meet the housing and community-based supports needs of individuals receiving services.
b. Continue to provide information to CSBs about grants and other funding opportunities that provide resources to meet housing needs.
c. Work closely with the VHDA, DHCD, and other agencies to maximize the use of all available resources and collaborate in developing and implementing affordable housing development plans for the benefit of low-income and homeless Virginians with mental disabilities.
d. Develop and implement strategies to implement the applicable housing-related recommendations in the Olmstead Task Force Report, including meeting with VHDA, DHCD, CSBs, Centers for Independent Living, Disability Services Boards, and AAAs to better understand differences in local and regional needs and strategies and to determine the local and regional prioritization of gaps needing to be addressed with state resources.

2. Provide safe, substance-free affordable housing to persons in recovery through existing and new Oxford Houses.

Action Steps:

a. Contract with Oxford House, Inc. or a similar organization to provide loan management services and technical assistance to individual Oxford Houses.
b. Provide technical support to existing Oxford Houses and to communities interested in establishing and collaborating with Oxford Houses.
c. Continue to support the loan fund.
d. Continue to establish relationships with individual Oxford Houses.
e. Establish a statewide association of Oxford House chapters.
f. Encourage networking among established Oxford Houses.

3. Explore the feasibility of home ownership for persons with cognitive disabilities in Virginia.

Action Steps:

a. Research what other states have pursued to assist individuals with mental retardation to achieve home ownership.

Goal 40: Improve the identification, screening, and diagnosis of substance abuse and substance use disorders and referrals to services by providers of primary health care services.

Objectives:

1. Provide opportunities for technology transfer to providers of primary health care services.

Action Steps:

a. Continue to seek resources and collaborative partners.
b. Continue to refine and revise "packaged" materials, such as the Substance Abuse Toolbox.
c. Develop multi-media, multi-staged approaches to education primary are providers.

Goal 41: Reduce barriers to employment for youth and adults with mental disabilities.

Objectives:

1. Increase access of individuals, family members, case managers, and public and private vocational and employment-related services providers to accurate information on existing SSI and SSDI work incentives.

Action Steps:

a. Continue to work with VCU, DSS, DRS and DMAS to customize WorkWORLD™ software for Virginia.
b. Collaborate in the development and implementation of the dissemination and training of Virginia's customized WorkWORLD™ software.
c. Strengthen the linkages to and utilization by individuals receiving mental health services, CSB case managers, and community support and psychosocial rehabilitation services staff to SSA Benefits Planning, Assistance, and Outreach providers and individualized benefits assistance planning.

2. Address the fears of individuals receiving services about the loss of health insurance and prescription coverage if earned income exceeds benefit thresholds.

Action Steps:

a. Continue to work with DSS, DRS, and DMAS to increase utilization of continual Medicaid coverage for individuals on 1619 (b) status with the Social Security Administration.
b. Continue to disseminate information, provide resources, and draft letters for use by individuals and case managers to assure continuation of Medicaid as allowed by 1619 (b) when individuals earned income exceeds SSI thresholds.
c. Continue to collaborate with the Disability Commission, DRS, DMAS, mental health constituency groups, and others in the development of the §1115 Research and Demonstration Waiver for a Medicaid Buy-In for Virginia.
d. Promote widespread utilization of Virginia's customized WorkWORLD™ Software by employment services providers.

Goal 42: Improve competitive employment opportunities and outcomes for individuals receiving mental health, mental retardation, and substance abuse services.

Objectives:

1. Improve knowledge about evidence-based employment practices for youth and adults with serious emotional disturbances and mental disabilities.

Action Steps:

a. Provide mental health community support, psychosocial rehabilitation, vocational, PACT, and other providers with information and knowledge on approaches to supported employment and the individualized placement and supports model of employment services.
b. Link mental health providers with existing Internet web-based instruction and courses on supported employment principles, services, and supports.
c. When available, disseminate the *Evidence-Based Practices Supported Employment Implementation Resource Kit* to public and private community mental health support services providers, DRS, and other entities as appropriate.

2. Expand the availability of evidence-based supported employment services and supports for youth and adults with mental disabilities.

Action Steps:

a. Identify inter-agency financial and organizational barriers to implementing Evidence-Based Practices of Supported Employment for adults with serious mental illness.
b. Encourage state agencies and others to clearly identify and articulate employment-related services and supports that can be supported by each state agency's respective funding streams and subsequently plan, develop, and implement joint training initiatives on this for individuals, family members, and providers.
c. Ensure the joint interagency training initiative for staff from all relevant agencies providing Medicaid employment-related services and supports includes an awareness of benefits and services provided.
d. Collaborate with DMAS to ensure that Virginia's Medicaid Rehabilitation Option incorporates all allowable employment-related services and supports, including supported education, for persons with mental illness in accordance with the National Governor's Association Best Practices recommendations.
e. Explore with DMAS the possibility of adding billable peer support services as a Virginia Medicaid Rehabilitation option.
f. Explore with DRS, Piedmont Community College, Region Ten CSB, and VHST the feasibility of adding curriculum to the provider training program for individuals receiving services that would prepare mental health individuals to be employed as peer support counselors with specific expertise in employment related supports and services, for example, WorkWORLD™ software.
g. Strengthen the emphasis on vocational and employment services and supports for individuals with a mental illness prior to discharge from a state psychiatric facility to the community and for all youth and adults with mental disabilities at intake to community mental health programs.
h. Continue to identify and, as appropriate, collaborate with DRS and other entities on federal and other grant applications that present opportunities for enhancing employment services, supports, and outcomes for young adults and individuals with a serious mental illness.
i. Continue to support organizations of individuals receiving services as providers of employment services and supports.
j. Continue collaborative efforts with DRS to increase access to vocational services, job training, and rehabilitation for individuals with mental disabilities; including cross-training initiatives for respective staff.

3. Expand the interagency agreement between the Department and DRS to include more CSB vocational assistance service sites for individuals receiving substance abuse treatment services.

Action Steps:

a. In collaboration with DRS, evaluate the impact of the agreement on employment, employment stability, and clinical outcomes.
b. Continue to provide technical assistance to CSBs participating in the agreement.
c. Continue to provide technical assistance and training to DRS counselors providing services through the agreement.
d. Enhance services as indicated by evaluation data.

Goal 43: Provide clinical leadership to the Interagency Drug Offender Committee.

Objectives:

1. **Collaborate in the design and delivery of services.**

Action Steps:

a. Continue to provide information concerning evidence-based practices for the screening, assessment, and treatment of offenders.
b. Provide technical assistance to criminal justice agencies to facilitate the development of contracts that support the delivery of services.
c. Seek additional resources through grants, budget initiatives, and collaborative planning.

Goal 44: Assure effective interagency collaboration and coordination necessary to reduce policy fragmentation and improve and enhance services and supports available to individuals with mental illnesses, mental retardation, and substance use disorders.

Objectives:

1. Continue to work with and support the Mental Health Planning Council to strengthen its effectiveness as an advocate for adults with serious mental illnesses and children and youth with serious emotional disturbances.

Action Steps:

a. Provide ongoing staff support to the operation of Mental Health Planning Council, including its review of the Mental Health Performance Partnership Grant.
b. Continue to support the Mental Health Planning Council's education initiatives for individuals receiving services and families.
c. Continue to participate in the development of mental health policy guidance for the Commonwealth.

***2. Provide useful guidance to the Governor, members of the General Assembly, and Executive Agencies regarding effective policies for coordinating substance abuse resources*.**

Action Steps:

a. Provide ongoing staff and funding support to the operation of Substance Abuse Services Council.
b. Continue to participate in development of substance abuse policy guidance for the Commonwealth.
c. Continue to support the development and dissemination of an interagency plan for substance abuse, involving as many relevant agencies as possible.

3. Work with the Commonwealth Partnership for Women and Children Affected by Substance Use to identify and resolve barriers to services.

Action Steps:

a. Continue to provide education and training to and to collaborate with other agencies regarding resources available to address the treatment needs of women with children.
b. Continue to meet and identify barriers to services and collaborative solutions that increase access to services and use available resources effectively and efficiently.
c. Continue to include a variety of representatives in discussions of local and statewide barriers and solutions.

4. Increase the number of interagency collaborative initiatives at state and community level that focus on and support collaborative prevention efforts.

Action Steps:

a. Continue and enhance the relationship of the Department with the Governor's Office for Substance Abuse Prevention to promote the development of prevention services, workforce, and resources.
b. Continue and enhance the relationship with the Department of Criminal Justice Services Juvenile Justice Delinquency Prevention Unit in providing technical assistance, training, and support in the community-based prevention planning process.
c. Continue and enhance the relationship with the Virginia Tobacco Settlement Foundation to collaborate on the administration of the biennial statewide youth survey and to institutionalize and expand the number of survey participants.
d. Continue and enhance the relationship with the Prevention and Promotion Advisory Council to the State Board to guide and advocate for evidence-based prevention services for children and families.
e. Convene a Prevention Advisory Council composed of representatives of the Prevention Task Force of the Virginia Association of Community Services Boards to assist the Department develop prevention policy, technical assistance and training.

Strengthening Human Resources Management and Development

Human Resources Development

There are several major human resources-related factors that are expected to affect the quality, responsiveness, and effectiveness of services provided through Virginia's publicly funded services system. These include:

- The aging and increasing cultural diversity of the current workforce,
- Declining enrollments in key degree programs such as nursing,
- The shortage of health care professionals and direct care workers, and
- The increasing level of skills expected of the workforce in the future.

A rapidly changing and more entrepreneurial economy has placed a premium on both adaptability and flexibility. Workers able to master technology and cope with change will have an advantage. Technology will increase the demand for highly skilled and well-educated workers. The economy's increasing emphasis on services will continue to create many new jobs that will be filled by workers who span the spectrum from highly skilled to moderately skilled workers, including many who might be candidates for recruitment by state facilities and community programs. Companies that cannot compete in the marketplace, even those that once had been monopolies, will not survive. As a result, workers will likely change jobs, employers, and even occupations more often than in the past. Workers in all occupations will need to prepare themselves mentally and professionally for this uncertainty.

With continuing budget pressures at the state and community levels, the overall size of Virginia's workforce is projected to grow slowly. This places pressure on providers to increase the productivity of individual workers. Accomplishing this requires technology improvements,

better matching of workforce skills with individual needs and acuity levels, and more education on new treatment modalities and professionally accepted clinical practices. Human resources training also is an important key to employee satisfaction and professional growth. A variety of education and compensation incentives will be needed to enhance skill levels and retain workers in key health care occupations, including expanded use of career ladders; on-site formal education for nurses, health care aides, case managers, and other licensed providers; tuition reimbursement; and grants for off-site educational programs. The community college system has expressed an interest and willingness to assist in this educational effort.

As Virginia's population becomes more diverse, providers must increase the cultural competence of workforce members. In July 2001, the U.S. Department of Health and Human Services Office of Minority Health released national standards on Culturally and Linguistically Appropriate Services (CLAS) in health care. These standards address culturally competent care, language access services, and organizational supports. Within this framework, these standards have three levels of stringency: mandates (intended for all recipients of Federal funds), guidelines, and recommendations. There is a federal mandate to identify the non-English languages that are used by individuals who access health and social services. Services providers must identify the:

- Language needs of individuals receiving services who have limited English proficiency,
- Points of contact in the organization where language assistance is likely to be needed, and
- Availability of resources and ways to access them to provide timely language assistance.

A multi-agency response to identify and provide trained and competent interpreters and other language assistance services may be appropriate and a more efficacious use of resources to ensure staff training.

Nursing Shortage

The continuing shortage of nurses has the potential to have significant service and financial impact on Virginia's publicly-funded mental health, mental retardation and substance abuse services system. The services system is having increasing difficulty attracting and retaining nurses, particularly in the area of mental health. This difficulty is being experienced by state facilities and community services providers across the Commonwealth.

Earlier this year, the Department conducted a workforce survey of the 15 state facilities, the 40 CSBs, and approximately 400 private providers across the Commonwealth. Responses were received from 31 percent of survey recipients. Almost half (48 percent) of the respondents indicated that they do not feel that it is relatively easy to obtain Registered Nurses or to retain well qualified Registered Nurses. Forty-eight percent did not feel that professional growth and development training opportunities are sufficient for Registered Nurses. The same percentage (48 percent) agreed that the system's public image has had a negative influence on the recruitment and retention of Registered Nurses.

The quality of publicly-funded mental health, mental retardation and substance abuse services is in serious jeopardy of being compromised due to growing difficulties of finding and retaining an adequate nursing workforce in state facilities, CSBs, and private provider organizations. Some organizations have reported a turnover rate reaching as high as 26 percent. This has resulted in significant overtime and contractual costs.

Continuing issues such as, compensation; public image; access and availability of basic and continuing education for the nursing profession; lack of career ladders; availability of qualified candidates for key specialty roles in mental health, mental retardation and substance abuse treatment settings; aging of the workforce; short tenure of the current workforce; increasingly physically and mentally demanding work environments; and the competitiveness of the market for qualified candidates have contributed to a partnership of the Department and it's facilities with the CSBs and private providers to examine workforce development issues.

The following workforce development initiatives are being developed to address these issues:

- Demonstration sites to encourage entry level and continued learning for CNA's, LPN's, and RN's into and within the system,
- Career ladders,
- System-wide public awareness campaign,
- Recognition program, and
- Partnerships to seek funding resources.

Direct Care Staffing Issues

One of the most serious problems identified by all oversight entities is the inability of providers to attract and retain qualified staff. Demand for Human Services positions, such as direct care workers, is growing more than twice as fast as all other industries. Yet, Virginia's mental health, mental retardation, and substance abuse services system is unable to meet current demand for direct care workers who provide essential hands-on care to individuals who must depend upon others for the most basic activities of daily living. As a consequence, the ability of many public and private providers to give needed levels of care and assure health and safety may, in the near future, be compromised if these providers cannot adequately staff and maintain their direct care workforce.

This problem affects individuals receiving care in state facilities, CSBs, and private programs. This includes individuals who rely on Medicaid-funded services and paid staff 24 hours per day on a long-term basis. The Department developed a workbook and test that must be administered to all direct care staff serving individuals receiving MR Waiver services. However recent utilization reviews conducted by DMAS found that some providers have failed to fulfill that requirement, meaning existing staff do not have even minimal preparation for their positions.

As service requirements and competencies have increased for direct care support personnel, the systemic issues of funding to adequately attract and compensate this workforce, providing adequate training and development for career growth, and providing recognition and value to the profession have remained basically unresolved. Public and private providers are being financially burdened, some to the point of reducing capacity or going out of business, due to:

- Stagnating reimbursement rates that no longer cover the costs of providing health care services,
- Extra costs associated with overtime or contract employees,
- Staffing levels that are inadequate to provide quality supports,
- Difficulty finding people to do the work,
- Difficulty attracting competent people to the field, and
- Excessive recruitment and training costs due to turnover.

Over 61 percent of the Department's workforce survey respondents stated that it was not easy to obtain direct service workers. Over two-thirds (66 percent) indicated that it was not easy to retain well-qualified direct service workers. Over three-fourths (79 percent) said that competition was high from other area employers. Thirty-five percent (35 percent) indicated that professional growth and development training opportunities were not sufficient. The same percentage (35 percent) stated that the system's public image was not a positive influence on recruitment/retention of direct care personnel. Turnover to alternate employers continues to exacerbate, ranging from 26 percent to 49 percent in some system providers.

The following workforce development initiatives are being established to address these issues:

- Continued learning programs utilizing long-distance learning techniques,

- Career paths linked to educational awards, e.g., certificates, specialized diplomas, AAS or AA degrees,
- Public awareness campaigns to recognize direct care services and opportunities offered by the services system, and
- Partnerships to seek funding resources.

As a partnership, public and private mental health, mental retardation, and substance abuse services providers will need to combine their efforts to strengthen the status of the direct support role and industry image; educate, train and develop frontline staff; develop career paths linked to education and training; secure systems change by improving income, linking wage enhancements to skill development; and revise public policy to provide the necessary tools for a transformation of the direct care worker to a direct care professional.

Substance Abuse Human Resources Issues and Priorities

The same technological progress that has fueled advances in evidence-based practices has also produced an urgent need for a well-trained workforce. At the same time, the existing workforce is "aging out" and is not being replenished with younger workers. Technology transfer to the existing workforce and the attraction and retention of a younger workforce are critical issues in the field of treatment for substance use disorders. To address these issues, the Department has joined forces with the Mid Atlantic Technology Transfer Center (Mid-ATTC) one of 15 such centers in the nation supported by the federal Center for Substance Abuse Treatment, to bring science to practice by accelerating the time it takes for new scientific discoveries to be integrated into mainstream treatment for substance use disorders. Established in 1990, Mid-ATTC is a part of the Virginia Commonwealth University Medical School. To this end, the Department and Mid-ATTC are engaged in several initiatives. The lynch pin of these initiatives is a co-located staff position responsible for human resource development (HRD).

Virginia Institute for Professional Addiction Counselor Training (VIPACT) - Originally a joint venture with the State of Maryland in the 1980s, VIPACT is an established curriculum to provide didactic training to entry level counselors and prepare them for the substance abuse certification examination offered by the Board of Counselors in the Department of Health Professions. The classes are provided at no cost to community services board employees or employees of agencies providing contractual services to community services boards. Working under the auspices of an interagency agreement with the Department, Mid-ATTC staff revised the curriculum in 2002, and the first "class" is completing its course work. Some of the classes provide experiential opportunities for learning, and some are taught via the Internet. Participants have ranged from entry-level workers currently employed in a substance abuse treatment program, to master's level mental health professionals who desired to expand their repertoire.

Virginia Summer Institute of Addiction Studies - As a member of the Consortium of Substance Abuse Organizations (CSAO), the Department was a sponsor of the Virginia Mini Summer Institute for Addiction Studies in 2002, and the first weeklong Virginia Summer Institute for Addiction Studies in 2003. CSAO membership is comprised of the Substance Abuse and Addiction Recovery Alliance (SAARA), the Virginia Association of Drug and Alcohol Programs (VADAP), the Virginia Association of Alcoholism and Drug Abuse Counselors (VAADAC), the Substance Abuse Certification Alliance of Virginia (SACAVA), the Substance Abuse Council of the VACSB, and the Task Force on Substance Abuse Services for Offenders (TFSASO). Both events were held on the campus of the College of William and Mary. The 2003 event included a graduate level course sponsored by the College. Department staff participated in planning both events and presented workshops. The Department sponsored keynote addresses from national experts. DOC and DCJS also supported the 2003 Institute.

Contractual Training in Evidence-Based Practices – Because the Mid-ATTC is a part of both Virginia Commonwealth University and a national network, the Department has been able to access clinical professors to provide training in evidence-based practices at CSB locations and stay abreast of programs and services provided by other TTCs throughout the nation. This access led to a series of training events in Motivational Interviewing at several CSBs that allowed CSB clinicians to receive ongoing consultation and training.

Special Training Events – In response to the upsurge in prescription drug abuse in the far Southwest region of Virginia, the Department joined with several contiguous states experiencing the same issues to apply to the Center for Substance Abuse Treatment for funds to support a conference. The Department also sponsored several regional workshops to address the issue, including national speakers. Numerous events involving other state agencies are conducted to provide cross training about a variety of issues, such as AIDS/HIV/TB and substance abuse (VDH) and women and substance abuse (VDH and DSS).

Prevention Training – Prevention has evolved into a science-based service and specific training in prevention theory and practice for CSB prevention management and staff is necessary for the implementation of effective prevention services in communities. Prevention training focuses on areas such as conducting community risk and protector assessments, developing community service plans that include all domains and people in the community, and implementing and evaluating evidenced-based prevention programs and activities. As very few universities provide specific training in prevention science and practice, prevention training and information must be made available from a variety of sources to reach and strengthen the CSB prevention workforce.

Behavioral Support Training

Many direct care workers employed by MR Waiver providers, as well as many new providers, do not have experience or training in how to work with the population served, particularly those with behavioral challenges resulting from co-occurring mental illness or autism. Best practice models of positive behavioral support are available, however training resources have been limited to Medicaid regulations for the past several years. The Department has not been able to develop or conduct more general training for direct care staff and providers. Another critical issue involves the development of professional staff with expertise in issues related to care of persons with mental retardation, including psychiatrists and behavioral consultants. Through a one-year pilot project with the University of Minnesota, the Department is exploring a web-based training program, College of Direct Support, for direct care staff serving people with mental retardation. This pilot project will assess the program's effectiveness and determine the feasibility of expanding this approach.

Goals, Objectives, and Action Steps

Goal 45: Partner with public and private organizations and providers to address systemic issues in fielding an adequate workforce within the mental health, mental retardation, and substance abuse services health care system.

Objectives:

1. Provide opportunities for services system partners to actively participate in system-wide workforce initiatives and build partnerships for effective collaboration and consensus on workforce issues and initiatives.

Action Steps:

a. Continue the Workforce Steering Committee as a mechanism to provide oversight of the system-wide Workforce Development and Innovation Initiatives with guidance from the Commissioner and the Department's Human Resource Development and Management Office.

b. In collaboration with the Workforce Steering Committee, proactively address system-wide workforce issues, support system-wide changes emerging from survey results and outcomes of Workforce Steering Committee subcommittee reports, and prioritize initiatives for system-wide changes.

c. Provide information and data to services system partners for assistance in addressing internal workforce issues.

d. In collaboration with the Workforce Steering Committee, plan and organize an educational forum, Workforce Summit II.

e. Provide support for quarterly meetings of the Workforce Steering Committee to meet quarterly to oversee and discuss initiatives, progress, and challenges of the system.

2. Develop a workforce development and innovation public awareness campaign in order to enhance the recruitment and retention of critical positions into the system and educate the public.

Action Steps:

a. Organize a task force team, representative of all partners, to collaborate on the development of a workforce development and innovation public awareness campaign.

b. Develop techniques to recruit and retain critical positions into the system via toll-free call center, space advertisements, TV public service announcements, radio public service announcements, interactive web site, web promotion, brochures, posters, direct mail campaigns, employee referral cards, bumper stickers, newspaper articles and profiles, radio interviews, forums, and exhibits and power point presentations for outreach programs.

c. Increase participation with primary, secondary, technical schools, and/or higher educational institution in order to educate the future workforce about the system and the rewarding work of mental health, mental retardation, and substance abuse services professionals.

3. Enhance the quality of the services system's workforce by developing or enhancing the recognition of mental health, mental retardation, and substance abuse services professionals within the Commonwealth.

Action Steps:

a. Develop CNA, LPN, and RN on-site educational programs that support career ladder progression for future and current nursing professionals.

b. Develop on-site educational programs that support career ladder progression for direct care professionals.

c. Evaluate and access continuing educational programs for critical positions by partnering with the community college system in order to offer continuing education credits or certificates.

d. Develop a system-wide recognition awards program.

4. Enhance the resources available to services system partners and create partnerships with educational institutions in order to promote continued learning.

Action Steps:

a. Evaluate distance learning concepts available for efficiency and effectiveness of staff on a statewide basis with educational institutions.

b. Pilot a nursing and direct care professional distance-learning techniques within a regional area of the state.

c. Establish and maintain a Workforce Development and Innovation Web Site as a resource for services system partners and the public.

5. ***Seek funding from federal, state, local, and private sources to support workforce development initiatives.***

   Action Steps:

   a. Establish a system-wide grant writing team to actively respond to applications for monies from the federal government and private sources for workforce development.
   b. Partner with state and local entities in support of workforce development and scholarships.
   c. Assist current workforce in obtaining scholarships and educational and/or financial aid in the health care field.

6. ***Implement a system of workforce planning for the Department in order to accurately project workforce needs and resources.***

   Action Steps:

   a. Develop a comprehensive workforce planning program that is linked to the Department's strategic plan and consistent with the requirements of the Virginia Department of Human Resource Management.
   b. Implement a workforce database in order to gather and analyze demographic workforce indicators.
   c. Develop the current workforce to have adequate skills and competencies to efficiently accomplish departmental objectives.

Goal 46: Enhance the skills and evidence-based knowledge of professionals working in substance abuse treatment and prevention programs.

Objectives:

1. ***Increase the basic knowledge and skill level about substance use disorders and evidence-based practices of current professionals and expose younger professionals to the field of treatment for substance use disorders.***

   Action Steps:

   a. Continue to implement VIPACT, revising the curriculum as needed.
   b. Continue to support the Virginia Summer Institute for Addiction Studies (VSIAS), by committing staff to planning and execution, with funding, and by urging participation by CSBs and their contract agencies.
   c. Continue to sponsor regional or onsite training offerings and seek other opportunities to enhance knowledge and skill in implementing evidence-based practices.
   d. Continue to support the Mid-Atlantic Training and Technology Transfer Center by collaborating and coordinating resources.
   e. Continue to respond to developing trends and issues by sponsoring workshops and training events.
   f. Continue to collaborate with other states and other state agencies to provide training.

2. ***Increase the number of training, support, and skill-building opportunities on evidence-based prevention services that address prioritized risk factors and un-served populations available to CSB prevention directors and staff.***

   Action Steps:

   a. Continue and enhance the activities of the Regional Alcohol and Drug Abuse Resource (RADAR) Center in the dissemination of prevention science and program information and materials.
   b. Provide orientation for new prevention directors and staff in prevention science and the prevention database.

c. Provide training and technical assistance to CSBs and other prevention professionals in community-based prevention planning, collaboration, and universal and selective evidence-based prevention programs, program development, and evaluation through the Virginia Summer Institute for Addiction Studies.
d. Support participation in national training opportunities such as the CADCA and National Prevention Network Research Conference.
e. Continue the development and expansion in technology capacity through training and technical support to CSBs in the use of the prevention data system.

Goal 47: Assure that the system of care for people with mental retardation is safe and efficient and delivered by professional and paraprofessional and direct care staffs that are well trained and motivated to support those who rely on them for their care and treatment.

Objectives:

1. Implement a variety of methods to recruit, train, motivate, and compensate professional, paraprofessional, and direct care staff.

Action Steps:

a. Gather information from the one-year College of Direct Support pilot to ascertain the effectiveness of the training program.
b. Enroll a wide variety of providers in the training to provide opportunities for increasing direct care staff skills by using a web-based training program.
c. Assess data on learning objectives of the College of Direct Support pilot curriculum.
d. Explore a certificate and associate degree program sequence for staff.
e. Revise the current MR Waiver Workbook to include additional information on positive approaches to supporting people with mental retardation and more information about people with a dual diagnosis.
f. Explore methods of developing incentives for direct care staff that engage in additional training, such as certificates, possible pay differentials or other methods of recognition for attaining higher levels of training.
g. Combine workforce efforts and work with the Positive Behavioral Support project as a means to develop more certified professional in the area of behavioral consultation.

Preparing for and Responding to Disasters and Terrorism

Services System Preparedness

In the aftermath of September 11th, the deliberate dispersion of anthrax spores, and the horrific events associated with the sniper attacks in Maryland and Virginia, it is no longer sufficient to develop disaster plans that are reviewed only when a threat appears imminent. Rather, a system of preparedness must be in place every day. Such a system makes effective responses to emergencies possible, it serves as a deterrent to actual attacks, and, most importantly, it serves as an essential cornerstone to facilitate preparations for and management of heightened states of alert (Code Orange) and crises that seem to be becoming more frequent occurrences.

Additionally, there is an expanded framework of expectations now in place to transition hospitals (including Joint Commission-accredited state mental health facilities) from an organization-focused approach to disaster preparedness to a broader emergency preparedness orientation that encompasses the entire community and its resources. A coordinated and well-developed system of preparedness first and foremost requires ongoing collaboration among key system partners. It also requires resources, leadership, and guidance. In order for the Department and

the state facilities to fulfill their responsibilities in planning and preparing for and responding to emergencies, the following resource and asset allocation considerations must be addressed.

Central Office Infrastructure

The Department's Central Office responds to virtually all significant *natural* disasters in the Commonwealth and has done so for almost twenty years. When the emergency is a terrorist event, however, the Department and its assets (i.e. facility staff, supplies, and space and CSB staff) become "first responders" because terrorism is a mental health event. Since 9/11, the Department has prepared or assisted in the preparation of and has administered fifteen different grants to provide mental health and substance abuse services to victims of terrorism or natural disasters. The Department also has been working closely with the state facilities to better organize and coordinate their individual and collective emergency response plans.

The Department recently received federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant funding through May 2005 to support one full time staff position in the central office devoted to disaster/terrorism response. This position will work to strengthen vital public-private partnerships needed to effect an appropriate emergency response; develop and implement training curricula for state facility, CSB, and public sector staff on emergency mental health response interventions; and work to establish mutual aid agreements among state facilities and between state facilities, community hospitals and other health care organizations in Virginia. Federal grant funding also is being sought by the VDH to support mental health preparedness activities in the Department's central office ($50,000) and in each CSB ($8,000 per CSB).

In a disaster situation, an additional emergency response position in the central office would be needed to allow one individual to perform necessary preparedness, immediate response, and coordination activities with state facilities and, as necessary, the CSBs, while the second individual would assist with these activities and would coordinate and prepare the grant-related activities needed to secure federal emergency response funding.

Funding to support augmented public information functions in the aftermath of a terrorism event is of critical importance, given the clear and pervasive mental health implications attached to such events. Accurate, timely, and instructive information must be available to the public to minimize fear and anxiety.

State Facility Preparedness

In light of the changed environment since the terrorist activities, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is sharpening its focus on preparing for events that disrupt healthcare organizations and the community. A significant clarification to the JCAHO emergency management standards, for example, replaces the term *disaster* with the term *emergency* in an effort to highlight the fact that organizations should be thinking about emergency management in terms of the four-phase process-mitigation, preparedness, response and recovery. The term *emergency* also represents the all-hazards approach and encompasses all possible crises-from natural disasters to acts of terrorism- that might face an organization.

The Department is working with state facilities to develop facility-specific emergency management plans that comport with JCAHO requirements. The state mental health facilities are JCAHO accredited and each has plans and processes that substantially meet these requirements. Emergency management plans for the mental retardation training centers will be similarly guided by the JCAHO emergency management plan template, however the scope of their plan processes is not intended to be as exhaustive as that developed by state mental health facilities.

The Department is developing internal agency policy that will outline the basic elements of a state facility emergency response plan. This template will include the four-phase emergency framework and will require state facilities to do the following:

- Conduct a hazard vulnerability analysis that identifies and prioritizes potential emergencies;
- Identify the state facility's command structure in its community and coordinate with community emergency management agencies to be ready for the priority emergencies;
- Identify specific procedures to mitigate, prepare for, respond to, and recover from the priority emergencies;
- Define an all-hazards command structure within the facility and link it to the community structure;
- Initiate the procedures in the plan's response and recovery phases;
- Notify external authorities of emergencies, including community emergencies identified by the facility, such as evidence of a possible bio-terrorism attack;
- Identify alternative roles and responsibilities of state facility and community command structures for response during an emergency;
- Educate all personnel, including licensed independent practitioners, who participate in implementing the emergency management plans; and
- Include the state facility's hazard vulnerability analysis in the annual evaluation of its emergency management plan.

A new element in the emergency management plan requires hospitals and long term care facilities to make cooperative planning with other health care organizations part of their plan (e.g. other hospitals providing services to a contiguous geographic area) to facilitate the timely sharing of information, resources, and assets in an emergency response.

Work is currently underway with all state facilities to develop a listing of all facility assets and resources (i.e. available staff, space, and supplies) that can be made available on both a short and long term basis in an emergency. Individual state facility and central office evacuation plans are also under development with the priority focus on contingency plans that allow for the pooling of assets and back-up accommodations within state facilities. Additional funds will be needed to prepare and implement state facility emergency management plans. While the state facilities are poised to assist in any community emergency response, Department policy requires that facility resources will first be made available to respond to the emergency response needs of state facility patients and residents.

Goals, Objectives and Action Steps

Goal 48: Enable Virginia's mental health, mental retardation, and substance abuse services system to better understand and prepare for the heightened threat potential facing the Commonwealth.

Objectives:

1. Provide training to all CSBs and state mental health and mental retardation facilities in crisis counseling and all hazards disaster response.

Action Steps:

a. Develop a multi-media training package that incorporates information on all hazard disaster response and incorporates the lessons learned from Virginia's response to the terrorism of 9/11/01, the serial sniper incident, and Hurricane Isabel, including risk communication and mass media strategies for intervention.

b. Provide sufficient copies of this training package to all CSBs and state facilities to enable them to share this training with local response partners.

c. Provide copies of this training package to other state agency responders such as the Virginia Department of Emergency Management and Virginia Department of Health as well as other public and private responders.

d. Provide at least one live all hazard training session per health planning region utilizing Community Resilience Project Managers as trainers for their CSB peers in conjunction with the Virginia Department of Health.

Goal 49: Establish structures and relationships that will assure an immediate, effective, and coordinated response to terrorism-related and other major disasters by the mental health, mental retardation, and substance abuse services system.

Objectives:

1. Link CSBs, state and private facilities, school systems, public health departments, faith communities, professional organizations, academic institutions and others into planning and response to disasters and terrorism–related events.

Action Steps:

a. Develop formal memoranda of understanding between contiguous CSBs to provide mutual support and response to disasters.

b. Encourage and assist CSBs to develop strong supportive working relationships with other local mental health and substance abuse providers and first responders.

c. Develop plans for regional state facility evacuation plans.

d. Assure that all state mental health and mental retardation facility disaster plans meet Joint Commission on the Accreditation of Healthcare Organizations standards.

2. Improve Central Office disaster response infrastructure and communication capabilities.

Action Steps:

a. Seek funds to provide disaster preparedness and recovery training, assistance, and support to state facilities and CSBs.

Implementing Information Technology Strategic Directions

VITA Transition

The 2003 session of the General Assembly passed legislation creating the Virginia Information Technologies Agency (VITA). Initiated by Governor Warner, its passage mandates the consolidation of information technology (IT) services for 94 Executive Branch Agencies within the Commonwealth, and promises to save tens of millions of dollars each year in the management of IT projects and purchasing of IT products. Transition of agencies to VITA began July 1, 2003 and will continue through the end of 2004.

The Department is scheduled to transition the majority of its IT staff to the VITA in 2005. Of the 94 IT staff employed by the Department's facilities and Central Office, 75 will be moving to VITA once a memorandum of agreement (MOA) is signed between the two agencies. The 19 remaining staff are application developers that support business systems and websites.

Of the 75 Department IT staff that will be moving to VITA, most are in technical positions that support hardware and network communication environments. Actual positions affected, as well as the responsibilities of those positions, are subject to negotiation through the MOA. In addition, the MOA will specify what IT services the Department expects from VITA and the business arrangements that will support them (rates, fees, office space, access, etc.). Work is expected to begin on the MOA in January or February 2004.

Information Technology Strategic Directions and Priorities

HIPAA Transaction and Code Sets

The Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Sets Rule is a federal law that applies to specific formats of individually identifiable healthcare transactions that are electronically transmitted. The law outlines the formats into national data standards surrounded by protocols for processing and transmitting over a public network. The Department's billing and reimbursement functions, which collect an average of $23 million per month in receipts for the Commonwealth, have been directly impacted by the promulgation of HIPAA regulations. To comply with the Rule, the Department is currently replacing its existing Patient/Resident Automated Information System (PRAIS) with a HIPAA-compliant hospital information system software package from Creative Socio-Medics Inc. called Avatar.

Clinical Application Software – The Department serves thousands of patients and residents each day in its facilities. In order to properly manage the care provided, clinical data in the form of thousands of transactions per facility per day needs to be collected, stored, and analyzed. Medical errors and operational inefficiencies can be drastically reduced with the availability of an electronic medical record with individualized electronic patient data such as:

- Treatment Planning
- Ancillary Service Orders
- Physician Orders
- Pharmacy
- Infection Control
- Assessments
- Discharge Planning
- Nutrition and Diet
- Seclusion and Restraints
- Critical Incidents.

Most of the above data currently only exists in the form of paper charts and files. While it is standard procedure for state facilities to share this data when patients are admitted, it most often takes days to arrive leaving the attending facility without a complete profile of the patient's treatment history. The Department needs to take advantage of the technology many private healthcare organizations in the industry are using. Having an electronic medical record supported by a complete suite of clinical applications has the potential to improve quality of care and patient satisfaction. It also will greatly reduce risk and increase operational efficiencies, resulting in cost savings to the Commonwealth.

Data Warehouse/Decision Support

The development of a common repository that stores integrated financial, clinical, and operational data across all state facilities, and eventually the CSBs, will provide the ability to measure public service delivery system utilization, performance, and resulting outcomes. Such a data warehouse will create a decision support environment that leverages data stored from different electronic sources and organizes it for access by decision makers across the system. The current data environment operates within a series of fragmented data systems that inhibit the ability to identify trends and patterns that would otherwise be seen if the data was fully integrated.

A decision support system (DSS) is needed to provide a standard series of screens and reports that can be used to monitor key performance indicators. The DSS will guide decision-making by offering "point and click" access to the data warehouse. It is critical that management begin using these performance metrics technologies that can assist in optimizing quality, appropriateness, and cost-effectiveness of care through clinical practice evaluation, clinical pathways development, benchmarking, and outcomes analysis. This system would directly support the requirements associated with risk management, quality improvement, and utilization review.

This data repository is also critical to the Department in satisfying external reporting needs such as federal block grant data requirements. These federal block grants provide millions of dollars each year for community-based mental health and substance abuse services. Any interruption

to these funding streams would seriously jeopardize the ability of the Department to achieve its mission.

IT Infrastructure Issues

In order to provide secure and adequate support to address the needs of Department staff and individuals receiving services, it is critical that the following infrastructure requirements be addressed.

- Maintain current levels of software to include operating systems, applications development software, and desktop software.
- Develop and utilize standard technology products to ensure seamless implementations of applications software and to promote interoperability. This includes hardware, operating systems, applications development and desktop software, and networking hardware and software.
- Establish and maintain adequate cable plants utilizing technology that provides secure and efficient network services to appropriate staff.
- Begin consolidation of technologies to reduce costs and improve service.
- Monitor network and server performance to ensure and maintain availability of services.
- Continue to implement Department-wide applications in order to streamline operations and eliminate redundant efforts.
- Establish service level agreements to ensure and develop means to measure satisfaction with services provided.

HPe3000 Retirement

Hewlett-Packard Inc. announced last year that its HPe3000 product line would be retired in 2005 and that it would also no longer be offering maintenance support. The Department has seven HPe3000 servers in five regional centers around the state. While it will be possible to obtain third party vendor support for a number of years after 2005, the effort to shift the two main business applications, FMS-II and the Human Resources Information System (HRIS) to a more stable platform needs to begin very soon. Other applications that are much smaller than the two main applications also need to be converted or phased out altogether.

Security

While the Department has had great success in updating and improving its Internet infrastructure and applying technology (firewalls, proxy servers, and software upgrades) to achieve effectiveness, it still remains vulnerable to attack. To reduce the risk of a successful attack against agency resources, it is critical that the Department perform a “white hat intrusion test” against its perimeter and internal defenses. This involves contracting with a reputable company that will attempt to penetrate past various levels of Department network and application layer security currently in place while fully documenting the successes and failures encountered. Measures can then be implemented to counter most possibilities of attack.

The HIPAA Security Rule, finalized and published in the Federal Registrar this past February 20, 2003, will also have a profound impact on Department operations. The Rule focuses on the following areas:

- Security and confidentiality practices
- Education and training programs
- Sanctions
- User authentication
- Access Controls
- Audit trails
- Physical security and disaster recovery
- Remote access points
- Risk assessment

In response to the Security Rule, the Department is investigating Virtual Private Network (VPN), Public Key Infrastructure (PKI), and secured server technologies. These technologies would

provide secured access to Department network resources via the Internet. While the Security Rule is technology-neutral, there are various levels of security that must be implemented by the mandated deadline of April 21, 2005.

Business Continuity

Applications written in the mid 1990s are in critical need to be re-written to a more robust software/database platform. For example, applications that had to be written quickly to meet a business need were developed using MS-Access with the intention of converting them to a more powerful and complex platform in the future. Since then, the functionality, as well as the number of records, has increased to the point where system performance is no longer acceptable. One such system, the Office of Licensing Information System (OLIS), which is the repository of all incident, death, inspection, and compliance information for all Department licensed programs in Virginia, is in danger of failure. With the 18 staff lost to the Workforce Transition Act of 1995 and the recent layoffs/separations of 9 additional IT professionals, it has become impossible to update these systems using current resources while maintaining/ developing the agency's other applications portfolio. Contract staff has been retained to address OLIS, but this is not possible for other systems due to budget constraints. Any new development projects will most likely result in some kind of delay or cancellation of other projects already in progress.

Risk Management Information

Housing, feeding, and providing care and services around the clock to patients and residents brings a high level of risk and liability to the Department. For example, the majority of state facility structures are over 50 years old. These structures were not built to today's standards for active treatment and habilitation services. Some have not been sprinkled for fire prevention. Data reflecting specific risks such as these needs to be collected, stored, and analyzed. Whether it is risk associated with a crack in a sidewalk or an old pill counting machine, software that tracks and analyzes such occurrences using predictive/preventive modeling techniques can drastically help to mitigate the risks. Risk management software is a critical piece in the overall effort to reduce risk not only to individuals receiving services, but also to the Commonwealth.

Human Resources Development Information

In the early 1990s, the Department developed its own Human Resources Information System (HRIS) to assist HR staff in tracking and managing agency personnel data. With the increasing difficulty of recruiting and retaining staff comes the increasing need to use information technology to track staff training/registration/certification, skill levels, evaluation monitoring, scheduling, grievances, timekeeping, salary, expertise levels, staff to patient ratios, benefits, leave usage, and education.

Community Consumer Submission (CCS) Implementation

Current information reporting requirements for each CSB have increased over the years due to additional state and federal accountability requirements and legislative expectations. The Department, by necessity, has developed multiple software applications to respond to these requirements and expectations. In addition, new federal reporting requirements for both the MH and SA Performance Partnership Grants will require very detailed information on individuals receiving services that is not currently readily available in existing applications (e.g., collecting demographic information in three-dimensional matrices).

The 2002-2008 Comprehensive State Plan recognized that multiple software applications and new federal reporting requirements could be met in a more efficient and less burdensome manner for CSBs and Central Office if data submissions could be streamlined. The Department and CSBs began exploring the feasibility of collecting required individual data from the CSBs as a secure single submission to the Department, rather than as multiple submissions that often were not secure.

This exploration has resulted in the design and pilot testing of CCS software developed by the Department, in collaboration with the VACSB. CCS software does not require any data entry. Instead CSBs will extract data from their local databases to import to CCS for the creation of a number of required reports or files. These include the federal substance abuse Treatment Episode Data Set system (TEDS), federal MH and SA Performance Partnership Grants, and the Department's Community Automated Reporting System (CARS), the system for the community services performance contract and reports.

The Department tested the CCS software at three pilot CSB sites through July 2003. All CSBs will implement CCS by early 2004. Once the CCS is fully implemented by all 40 CSBs, it would take the place of existing reporting applications that CSBs currently use to report individual service recipient and service data to the Department.

CCS represents a fundamental change in how the Department collects most individual service recipient and service data from the CSBs. There are several reasons why this proposed change to CSB data collection is attractive. It would:

- Provide, for the first time, a truly unduplicated count of individuals receiving services by accounting for individuals who move among CSBs or between CSBs and state facilities;
- Improve data quality and reliability, which is especially important given the increasing emphasis on performance in federal block grant reporting;
- Greatly reduce the reporting burden on the CSBs -- for routine reports as well as for ad hoc reporting requests for Department decision-making and budget planning;
- Provide specific service and demographic information on individuals receiving services that could be useful for performance measurement; and
- Result in efficiencies at the state and CSB levels from automating the single file output as opposed to collecting data and keying or importing it into many different reporting applications. Such efficiencies are essential because budget reductions have reduced Department and CSB IT staffs.

CCS may be enhanced over time, if sufficient resources become available, to include additional information, including data elements that may be useful for outcomes measurement.

Two other Department information technology priorities are the Utilization Management Infrastructure and Medications Tracking System. These are described in Assuring Service Quality, Effectiveness, and Responsiveness in a Restructured System of Care (see pages 99 and 100).

Goals, Objectives, and Action Steps

Goal 50: Assure that the information technology infrastructure and services provided by the Virginia Information Technologies Agency (VITA) to the Department match the Department's evolving demands in a cost effective manner and perform in a reliable and secure manner.

Objectives:

1. Work with VITA to develop and implement the transition of Department's information technology equipment and selected information technology staff to VITA.

Action Steps:

a. Appoint an Agency Information Technology Resource (AITR).

b. Negotiate and implement a Memorandum of Agreement with VITA to cover project deliverables, operational transition of Department IT staff and infrastructure, capacity management, continuity management, availability management, security management,

financial management of information technology service expenditures, and computing environment management processes.

c. Participate in information technology capacity and resource planning for services.

d. Perform information systems disaster recovery testing.

e. Update the Department's Information Technology Strategic Plan, as necessary, to reflect agency business needs.

f. Host a quarterly review meeting with VITA representatives to discuss new information technology services, VITA performance measures, analyses of improvement opportunities, and other issues.

Goal 51: Improve the ability of the Department, state facilities, and CSBs to manage information efficiently in an environment that is responsive to the needs of users and protects identifiable health information for individuals receiving public mental health, mental retardation, and substance abuse services.

Objectives:

1. Implement the Department's Information Technology Strategic Plan.

Action Steps:

a. Implement hospital information system software in all state mental health and mental retardation facilities to meet the federal Health Insurance Portability and Accountability Act (HIPAA) transaction and code sets rule.

b. Develop an electronic medical record supported by a complete set of clinical applications in all state mental health and mental retardation facilities.

c. Implement a data warehouse that provides a common repository for storing integrated financial, clinical, and operational data across all facilities and a decision support system offering "point and click" access to the data warehouse.

d. Address agency infrastructure requirements related to current operating systems and software, interoperability, security, network and server performance, potential areas for consolidating or streamlining, and user satisfaction.

e. Seek funds to replace the HPe3000 server with a more stable platform.

f. Implement the HIPAA Security Rule by the mandated deadline of April 21, 2005.

g. Convert existing applications to platforms that allow more powerful and complex performance.

h. Develop risk management software.

i. Develop human resources software.

j. Implement the Community Consumer Submission (CCS) software.

k. Implement the MedIs medications tracking software.

l. Implement a utilization management infrastructure.

VI. RESOURCE REQUIREMENTS

The Department has identified the following resource requirements to respond to critical issues facing Virginia's services system. Resource requirements that are part of the Department's response to the Olmstead vs. L.C. Supreme Court decision and Virginia's Olmstead Task Force Report are asterisked.

**** Restructuring: Crisis Stabilization, Emergency/Rapid Assessment/Referral Options to Inpatient Treatment*** –State general fund resources totaling $4,331,250 in FY 2005 and $5,775,000 in FY 2006 are required to establish a 6-bed regional crisis stabilization program for adults in six regions of Virginia and one crisis stabilization program for youth in the Tidewater region (which is farthest from any state child and adolescent inpatient services). These intensive residential programs would provide crisis intervention and treatment on a 24-hour basis, through a multi-disciplinary staff (including psychiatric and medical treatment by physicians and nurses), to persons whose psychiatric conditions meet, or nearly meet, hospital level-of-care requirements.

**** Restructuring: PACT Teams*** – State general fund resources totaling $2,219,043 in FY 2005 and $4,438,086 in FY 2006 are required to expand Virginia's Programs of Assertive Community Treatment (PACT) with five new teams at CSBs that are implementing restructuring initiatives. These new teams would serve 400 individuals with serious mental illness who have histories of long or frequent inpatient stays and would reduce state hospital usage by this population by approximately 80 percent by the end of the biennium (after a start-up period).

**** Restructuring: Local Psychiatric Bed Purchases*** – State general fund resources totaling $6,570,000 in FY 2005 and in FY 2006 are required to support the purchase of local acute inpatient services equivalent to 20 beds in the Southern, Southwestern, and Western Virginia regions. These regions have historically invested in local inpatient bed purchase to a lesser degree than other areas of Virginia. Resources also are required to establish a public-private partnership to develop a 10-bed specialized inpatient unit designed to increase access to timely and appropriate inpatient care for individuals with challenging behaviors and complex treatment needs.

**** Restructuring: Transitional Residential Services*** – State general fund resources totaling $6,690,000 in FY 2005 and $10,380,000 in FY 2006 are required to expand Virginia's mental health transitional residential highly intensive and intensive services by adding 100 beds at CSBs that are implementing restructuring initiatives. These new community residential beds would serve approximately 565 individuals with serious mental illness who have histories of long or frequent inpatient stays, thereby reducing their state and local hospital usage. These transitional residential services will help individuals avoid unnecessary hospitalization by providing structured 24-hour care in the community.

**** Restructuring: Consumer and Family Involvement in Regional Partnership Planning*** – State general fund resources totaling $110,000 in FY 2005 and in FY 2006 are required to support meaningful participation by individuals and family members in Regional Partnership Planning, the Special Populations Work Groups, the Restructuring Policy Advisory Committee, and the Services System Partner Open Forums. These resources would pay individuals receiving services and family members for the costs incurred by participating on the RPAC and in Open Forums. This involvement increases the likelihood of successful implementation of state and community reinvestment strategies, which are essential to developing a community-based system and meeting Olmstead objectives. Many individuals and family members would not be able to participate in these activities without mileage reimbursement and other supports.

**** MH State Facility Discharge Waiting Lists*** – State general fund resources totaling $4,518,750 in FY 2005 and $6,025,000 in FY 2006 are required to reduce the census of state mental health facilities by discharging 85 long-term state mental health facility patients who are on state facility ready for discharge lists to appropriate community services through Discharge

Assistance Projects (DAP). The current "ready for discharge" population targeted under this effort has significantly more intensive and often multiple medical, behavioral, and psychological needs that require a greater intensity of services and supports with an average cost of $70,000 per year. The resulting expansion of community mental health services would reduce state hospital census, avoid unnecessary admissions, and increase community tenure among adults with serious mental illness. There are 354 existing DAP enrollees and 50-75 additional individuals who could be enrolled in DAP through current reinvestment initiatives, not including the 85 enrollees identified here. Therefore, one position is also required to provide oversight and monitoring of these individuals, support to inpatient and CSB providers who will be working with these persons, and data management.

**** MR State Facility Discharge Waiting Lists*** – State general fund resources totaling $4,187,211 in FY 2005 and $3,004,568 in FY 2006 are required to develop community-based services for 175 persons who have chosen community services rather than continued placement in a state-operated training center and who have been determined to be clinically ready for discharge. Resources also are needed to cover two additional licensure staff needed to license new providers and two additional human rights staff to serve the needs of the persons being served. The strategy for developing needed community-based services would be to request state matching funds for services funded through the Mental Retardation Home and Community-Based Waiver to be included in the DMAS budget. Average MR Waiver costs for persons discharged from state facilities is $72,500 or $35,520 in state general funds. Community placements would be initiated through individualized plans of care developed by CSBs and preauthorized by the Department.

**** Community MH Services Waiting Lists*** – State general fund resources totaling $9,004,600 in FY 2005 and $18,549,500 in FY 2006 are required to provide mental health services for adults and children and adolescents on CSB waiting lists for community services. As part of the planning process for the 2004-2010 Comprehensive State Plan, CSBs reported that 5,030 adults with serious mental illnesses and 1,314 children and adolescents with or at risk of serious emotional disturbances (unduplicated numbers) were on waiting lists for services, a total of 6,344 individuals. As the CSB waiting list information documents, the system of care has many critical gaps that need to be filled. Unless they receive needed community services, individuals on MH waiting lists risk:

- Escalation of mental health problems to the point that some adults and children become dangers to themselves or others or become substantially unable to care for themselves;
- Deterioration of functioning or life circumstances that could cause children and adults to need longer-term or more restrictive and expensive services;
- Failure to support recovery from mental illness and prevent involvement with the criminal justice system and impaired psychological, social, and vocational functioning; and
- Increased risk of inappropriate admission to state inpatient treatment facilities.

These resources would address half of the CSBs waiting lists in 2004-2006.

**** Community MR Services Waiting Lists*** – State general fund resources totaling $9,479,900 in FY 2005 and $19,528,600 in FY 2006 are required to provide mental retardation services for individuals on CSB waiting lists for community services. As part of the planning process for the 2004-2010 Comprehensive State Plan, CSBs reported that 2,656 individuals (unduplicated numbers) were on waiting lists for services. As the CSB waiting list information documents, the system of care has many critical gaps that need to be filled. Unless they receive needed community services, individuals on MR waiting lists risk:

- Deterioration of functioning or life circumstances that could cause individuals to need longer-term or more restrictive and expensive services; and;
- Increased risk of inappropriate admission of individuals to state training centers.

These resources would address half of the CSBs waiting lists in 2004-2006.

**** Community SA Services Waiting Lists*** – State general fund resources totaling $3,419,200 in FY 2005 and $7,043,400 in FY 2006 are required to provide substance abuse services for

adults and adolescents on CSB waiting lists for community services. As part of the planning process for the 2004-2010 Comprehensive State Plan, CSBs reported that 2,997 adults and 287 adolescents (unduplicated numbers) were on waiting lists for services, a total of 3,284 individuals. As the CSB waiting list information documents, the system of care has many critical gaps that need to be filled. Unless they receive needed community services, individuals on SA waiting lists risk:

- Escalation of substance use disorders to the point that some individuals become dangers to themselves or others or become substantially unable to care for themselves;
- Deterioration of functioning or life circumstances that could cause children and adults to need longer-term or more restrictive and expensive services;
- Use of local jails to house habitual public inebriates, with little likelihood of improving their stability or employment situations;
- Deterioration of family structures resulting in increased demand for foster care and other child welfare and safety services;
- Inappropriate use of health care resources, such as emergency rooms, and increased morbidity and mortality related to substance use disorders; and
- Failure to address problems related to untreated substance use disorders, such as communicable diseases, criminal justice system involvement, and impaired psychological, social, and vocational functioning.

These resources would address half of the CSBs waiting lists in 2004-2006.

**** Medicaid MR Waiver Rate Increase*** – State general fund (GF) and non-general fund (NGF) resources totaling $15,000,000 (GF) and $15,000,000 (NGF) are required in each year of the biennium to provide a 15 percent increase in rates for Medicaid congregate residential and day support services. This increase is necessary to retain qualified staff, attract new and maintain existing providers, and ensure health and safety for service recipients as part of the services system's response to the Olmstead Decision.

**** Medicaid MR Waiver Urgent Waiting List*** – State general fund (GF) and non-general fund (NGF) resources totaling $11,600,000 (GF) and $11,600,000 (NGF) in FY 2005 and $23,200,000 (GF) and $23,200,000 (NGF) in FY 2006 are required to provide an additional 500 MR Waiver slots in each year of the biennium (total of new 1,000 slots) for individuals on the Urgent Care waiting list.

Jail-Based MH/SA Services – State general fund resources totaling $477,024 in FY 2005 and $491,335 in FY 2006 are required to divert forensic admissions of jail inmates from state facilities, when clinically appropriate, and provide an innovative approach to expeditious service provision for inmates with mental illnesses. Treatment to restore competency to stand trial would be provided in a selected regional jail, when deemed clinically appropriate. Staff at a selected state facility would provide the following services in the regional jail:

- Psychiatric, psychiatric nursing, psychological, and social work assessments;
- Prescription, administration, and delivery of psychotropic medications;
- Competency restoration services, forensic evaluations, and cross-training in mental health to jail staff for coordination of care;
- Individual and group counseling and case management services to facilitate post-release adjustment to the community; and
- Technical assistance and support for implementation of on-site medical information management and case management data systems and for coordination of court and hospital communication and scheduling.

**** Pilot Residential Program for Discharged Forensic Patients*** – State general fund resources totaling $481,988 in FY 2005 and $500,000 in FY 2006 are required to develop a pilot specialized, highly intensive 8 bed residential program for forensic patients who are ready for discharge from state mental health facilities and are in need of active supervision and intensive community support and monitoring, in order to prevent relapse and re-hospitalization and enable them to adjust successfully to community placement. Individuals included in this

category include: insanity acquittees who have been approved for conditional release, but for whom appropriate community housing is not available; individuals who have been found unrestorably incompetent to stand trial and no longer are in need of hospitalization; and mandatory parolees whose histories of high risk behaviors render them difficult to place in other community housing, despite their current state of positive recovery. Individuals to be referred to this facility would be selected by a committee composed of the director of the program, state hospital staff, and CSB aftercare planning staff for the area serving the residential program. The individuals would be expected to conform to the requirements of conditional release or other discharge plans and to maintain appropriate employment or participate in an active regimen of rehabilitation, in order to remain in the program.

Child/Adolescent Service Capacity Expansion – State general fund resources totaling $4,075,000 in FY 2005 and $5,075,000 in FY 2006 are required to fund specialized services for children and adolescents to improve their functioning at home, school or in the community. These funds would support specialized services to the following populations:

- Children and adolescents with or at risk of serious emotional or behavior problems,
- Child and adolescent offenders with mental illness and/or substance abuse who are involved in the criminal justice system,
- Youth with co-occurring mental illness and mental retardation who are at-risk of hospitalization or who are hospitalized in state facilities, and
- Youth ages 14-21 requiring services and supports to successfully transition from special education to adult living. Services would be provided through CSBs.

These resources, allocated regionally, could be used for startup to initiate programs or provide matching dollars for state, federal or private grants. In addition, one position is required to coordinate program development, provide technical support to CSBs, and monitor program implementation and outcomes.

CSB Child Psychiatrists and Specialists – State general fund resources totaling $3,000,000 in FY 2005 and $4,000,000 in FY 2006 are required to fund board-eligible or certified psychiatrists, licensed therapists, and advanced practice nurses to provide psychiatric assessments, evaluations, and treatment to children and adolescents with mental illness at community services boards. These specialized services would allow children and adolescents to remain in their homes and communities, rather than being sent out-of-home or out-of-community for treatment.

Part C Early Intervention Services – State general fund resources totaling $3,344,663 in FY 2005 and $6,265,363 in FY 2006 are required to replace one-time unexpended Federal Part C Funds from previous fiscal years and DSS Child Care Development block grant funds that currently provide services to between 600-800 infants and toddlers with special needs each year and to serve 214 infants and toddlers on CSB waiting lists as of April 11, 2003 and 1,349 infants and toddlers who are projected to need services over the biennium. Virginia's Part C federal fund allocation from the Office of Special Education Programs has not kept pace with the increased needs of the system, although, according to federal legislation, services are required to be provided. Federal and state funds that are currently dedicated to serving all identified infants and toddlers are not adequate and the number of children entering the Part C system each year increases by an average of 8 percent. One-time unexpended Federal Part C funds from previous fiscal years that are now being used to serve children eligible for Part C early intervention services will expire in December 2004. The Department also was recently notified that $1 million in federal funds from the DSS Child Care Development block grant funds would no longer be granted for Part C eligible children.

MR Services for Children with Complex Needs – State general fund (SGF) and non-general fund (NGF) resources totaling $675,480 (SGF) and $524,520 (NGF) in FY 2005 and in FY 2006 are required to develop a community-based facility to serve children with mental retardation who also have on-going health conditions that are so severe that they require constant and close medical supervision. While a home setting is most appropriate for the majority of children with

mental retardation and even for those with medical involvement, some children are so medically fragile and dependent on medical technology that their needs cannot be met in a regular family dwelling. This facility would need to be located in close proximity to a medical center that has the expertise in providing specialized pediatric care. The facility also could provide respite care for families who have medically fragile children with mental retardation.

**** MI/MR Regional Clinical & Emergency Support Teams*** – State general fund resources totaling $240,000 in FY 2005 and $480,000 in FY 2006 are required to establish two community clinical teams in FY 2005 and two teams in FY 2006 to address special biomedical and psychosocial issues, psychotropic medication use and side effects, and positive behavior support intervention procedures for persons with complex MH/MR (dual diagnoses) issues. Each team would include a psychiatrist, a behavior specialist, a physician or nurse practitioner/physician assistant, and on call direct care staff who are specially trained to provide in-home crisis stabilization support during crises, in lieu of admission to a state facility, and teach staff on-site for two weeks after as needed. The team also would provide clinical consultation and follow-up, emergency direct care staffing, and training to the current physicians, clinical staff and direct care support staff to assist in stabilization of psychiatric issues, development of positive support treatment plans, identification possible undiagnosed medical conditions. Teams would be contracted on a part time basis for 10 hours per week, with project coordination with the MH/MR facilities and CSBs.

**** Restructuring: Southwestern Virginia MI/MR Waiver Slots*** – State general fund resources totaling $425,000 (NGF) in FY 2005 and in FY 2006 are required for 10 Medicaid MR Waiver slots needed to return 10 individuals at SWVTC with dual diagnoses of mental retardation and mental illness to the community. Normally these individuals would be served in the state facility and would be unable to live in a more integrated community setting because of their problematic behaviors. SWVTC has just established a new regional MR/MI program that will provide short-term behavioral, medical and developmental interventions and necessary supports and treatment for successful transition of these individuals to the community. Although individuals receiving these services would be eligible for the MR Waiver, many would not have waiver slots initially. These slots, which are estimated to cost between $70,000-$100,00 per slot, are critical to the program's success in returning patients to the community, so the beds would become available to others who could best be served by the program.

**** Regional Community Support Centers (Centers of Excellence)*** – State general fund resources totaling $1,000,000 in FY 2005 and in FY 2006 are required to replicate the NVTC Regional Community Support Center (RCSC) project in the other four training centers. For individuals who live in the community, medical, dental, and behavioral health services offered through community options often do not adequately serve the needs of persons with severe and profound mental retardation or persons who have complex medical, behavioral, and mental health needs. The RCSC concept provides access to these services through training center medical professionals and clinicians with special expertise in the treatment of people with mental retardation. An individual's CSB case manager would secure the services from a training center through a referral process. In addition to specialized outpatient care in medical, dental, and behavioral health, training center staff would provide training to community staff and specialized educational opportunities for students in cooperation with area universities.

Evidence-Based Practices – State general fund resources totaling $385,000 in FY 2005 and $660,000 in FY 2006 are required to develop, disseminate, support, and enhance evidence-based practices (EBPs) and quality services of proven effectiveness to individuals receiving services. These resources would develop an EBP web site managed by the Department targeted to providers, individuals, and family members and provide related resources to support the implementation of best practices and EBPs in mental health, mental retardation, substance abuse, prevention, youth and family, and offender services. Two "Centers of Excellence" affiliated with Virginia universities would work to adopt mental health EBPs through direct

training, program technical assistance, and clinical consultation for CSB practitioners. One Center would be implemented in FY 2005 and a second Center would be added in FY 2006.

Behavioral Rehabilitation Center (SVP) Staffing and Operations – State general fund resources totaling $3,746,667 in FY 2005 and $5,740,412 in FY 2006 are required for the Department to meet its statutory obligation to operate a special, maximum-security mental health program for civilly committed sexually violent predators. This program provides treatment for persons deemed too dangerous to be released into their communities upon completing imprisonment. The program's census is projected to grow, with approximately two commitments per month, to approximately 75 residents by June 30, 2006. Staffing needs and costs will continue to grow with census during this period.

SVP Community Treatment – State general fund resources totaling $325,000 in FY 2005 and $534,000 in FY 2006 are required to provide community-based services to those sexually violent predators who have been conditionally released by the courts to the community. The Department estimates that approximately six eligible sexually violent predators will be conditionally released into the community each year. Each release will require the services of a case manager, housing, employment assistance, drug and alcohol treatment, sex offender specific treatment, and electronic and individual monitoring to insure abstinence from sexual offending. By statute, the Department is responsible for providing or arranging for the provision of these conditional release services and for monitoring individuals receiving these services. The conditional release program is at present unfunded.

MR State Facility Staff– State general fund (GF) and non-general fund (NGF) resources totaling $9,317,552 (GF) and $7,235,215 (NGF) in FY 2005 and $10,249,307 (GF) and $7,958,736 (NGF) in FY 2006 are required to addresses the clinical staffing needs at Central Virginia Training Center, Southeastern Virginia Training Center, Southside Virginia Training Center, and Southwestern Virginia Training Center to move these training centers towards the clinical staffing expectations established under the Northern Virginia Training Center agreement with DOJ under the Civil Rights for Institutionalized Persons Act (CRIPA). These training centers now primarily serve individuals who function at severe and profound levels of mental retardation, many of whom also have multiple, complex medical needs such as seizures, scoliosis, gastro-intestinal problems, hearing and/or visual deficits or loss, and speech impairments. System-wide, a large proportion of these individuals is non-ambulatory (requiring specialized wheelchairs) or needs significant staff assistance to walk. The resident populations at all training centers are aging, resulting in increased medical needs. All of the conditions stated above make appropriate staffing critical to the provision of constitutionally adequate levels of care.

MH State Facility Staff – State general fund (GF) and non-general fund (NGF) resources totaling $1,446,870 (GF) and $142,228 (NGF) in FY 2005 and $1,591,482 (GF) and $156,823 (NGF) in FY 2006 are required to move the state mental health facilities towards the clinical staffing expectations established under the agreements with DOJ based CRIPA by increasing direct care and clinical staffing at Southwestern Mental Health Institute, Southern Virginia Mental Health Institute, and Commonwealth Center for Children and Adolescents.

State Facility Medications Costs – State general fund (GF) and non-general fund (NGF) resources totaling $2,752,246 (GF) and $440,615 (NGF) in FY 2005 and $3,303,078 (GF) and $528,355 (NGF) in FY 2006 are required to increase the level of funding for pharmaceutical costs, largely to offset the increased cost of atypical or second-generation antipsychotic medications. The cost of these medications is increasing at approximately 20 percent each year. These medications are the standard of care for treatment of many severe mental illnesses. They have fewer side effects and provide symptom reduction and illness remission in individuals with severe mental illness. Specific advantages of these medications include improved compliance to medication regimes, shorter hospitalizations, increased time between hospitalizations, and decreased Tardive Dyskinesia, a long-term neurological disorder.

State Facility Equipment, Telecommunications, and Van Replacements – State general fund (GF) and non-general fund (NGF) resources totaling $584,175 (GF) and $250,362 (NGF) in FY 2005 and in FY 2006 are required to meet a variety of care needs in state facilities. These include, but are not limited to the following needs:

- Purchases of patient and resident care equipment, including bed enclosures, medication carts, bathing systems, body immersion devices, resident hydraulic lifts, medical and dental equipment, wheelchairs, and beds to meet new CMS bed guidelines.
- Purchases of vehicles that can pass inspection are required for transport of patients and residents. Many of the vehicles maintained by the state facilities have exceeded safe mileage and repair parts and labor exceed cost effectiveness. Seven facilities need vans to assure patient or resident transport for physician visits, discharge placement visits, and community activities that assist with treatment and habilitation. At three of these facilities, over half of the patients or residents is non-ambulatory and requires wheel chair vans.
- Upgrades in telecommunications and computer equipment and software, including time keeping systems. Such upgrades are critical to data management relative to resident and patient treatment records for reimbursement, for discharge planning purposes, and for ongoing facility operations data management.

State Facility Gas and Fuel Costs – State general fund (GF) and non-general fund (NGF) resources totaling $670,960 (GF) and $226,250 (NGF) in FY 2005 and $686,922 (GF) and $238,761 (NGF) in FY 2006 are required to cover current and anticipated increases in state facility utility costs, particularly heating oil and natural gas. Funds to address these higher costs must be absorbed from other facility budget lines, resulting in insufficient inventories and repair materials and inadequate funding for appropriate staffing levels.

State Facility Surrogate Decision-Makers – State general fund resources totaling $90,000 in FY 2005 and $40,000 in FY 2006 are required to cover guardianship costs, training, and recruitment efforts that are needed to increase the number of state facility surrogate decision-makers. There are approximately 175 residents in state facilities that need a guardian or another type of substitute decision-maker. A similar need exists for individuals receiving services from community providers. The average fee for each guardianship proceeding and appointment is $2000 per year. Resources are specifically needed to:

- Provide grant dollars to the VACSB in FY 2003 to develop a model of private non-profit guardianship corporations that can be replicated throughout the state.
- Provide funds to state facilities to recoup part of the cost of guardianship proceedings.
- Develop a curriculum and training program that results in participants receiving Court-approved certification to serve as substitute decision-makers in order to increase the pool of surrogate-decision makers.

State Facility Revenue Shortfall – State general fund resources totaling $14,800,000 each year of the biennium are required to offset the decline in special funds collections resulting from a decline in census and Medicaid billable days. Maximum revenue for services being provided is being reached; however, the corresponding revenue amount is insufficient to meet the appropriation requirements for third party collections. Positive Medicaid cost settlements have covered declines in census and corresponding Medicaid billable days, which have been occurring over the past several biennia. Due to declining operating costs resulting from budget reductions, there is little fluctuation in annual costs. Therefore, no anticipated positive cost settlements are projected. Failure to resolve this shortfall will require a reduction in staffing by 380 jobs, which would adversely affect the delivery of services to state facility patients and residents.

Nursing Development, Recruitment/Retention – State general fund resources totaling $911,667 in FY 2005 and $1,335,924 in FY 2006 are required to support a comprehensive initiative to develop, recruit, and retain nurses and direct care staff in Virginia's mental health, mental retardation, and substance abuse services system. Initiative components include:

- Improving the overall compensation package for registered nurses in state facilities, specifically base salaries, for employees who have salaries that are out of alignment with the market for their level of experience and education and developing a clinical career ladder that allows employees to advance by increasing their professional skills and taking on management responsibilities;
- Creating a demonstration site for the development of direct care employees into certified nursing assistants, licensed practical nurses, and registered nurses by offering a regional educational program for state facility, CSB, and private system providers and building a career ladder for direct care workers, linked to educational awards such as specialized certifications, specialized diplomas, and AAS or AA degrees, that would allow employees to advance by increasing their professional and clinical skills;
- Updating service system recruiting materials and developing system wide employee recognition materials, brochures, videos, and other media that facilitates recruitment efforts;
- Developing partnerships with public and private entities to seek and receive funding resources; and
- Implementing direct care worker learning programs utilizing on-site distance learning techniques, such as the College of Direct Support (an interactive web-based training program), that allow operational and organizational flexibility in responding to the specific needs of individuals and organizations.

Terrorism/Disaster Preparedness – State general fund resources totaling $172,500 in FY 2005 and in FY 2006 are required to add two additional full-time positions to accomplish the tasks necessary for the mental health, mental retardation, and substance abuse services system to appropriately prepare for and respond to terrorism and natural disasters. These staff would work with the Department's Disaster Preparedness and Response Director to develop agency emergency preparedness needs assessments, plans, and protocols; develop and maintain interagency linkages with universities, the State Health Department, and private response agencies; provide consultation to state facilities and CSBs as they develop their own disaster response protocols and procedures; and provide training to facilities, CSBs, and the central office on continuity of operations requirements.

CO IT Systems Development Facility Quality Improvement Staff – State general fund resources totaling $155,000 in FY 2005 and in FY 2006 are required to fill two CO positions. The continued vacancy of the Central Office IT Manager I – Systems Development Manager position presents serious risks to the Department. This position oversees and maintains over one hundred business applications that span Central Office and the 16 state facilities. Twenty of these applications are critical to the operations of the agency. With the upcoming assignment of the current Department's chief information officer to VITA, the Department will have no IT leadership for the 15 CO development staff not assigned to VITA. Resources also are required to fill one position within the Department's Office of Facility Operations/Quality Improvement. This office is responsible for a broad array of services to the Department as a whole, to the state facilities, and to a number of external reviewers, including JCAHO, CMS, the OIG, and VOPA. This Office has limited resources to identify in a timely manner concerns and risks to the Department, to respond in a timely manner to the variety of constituents, to provide technical assistance to facilities in best practices, and to utilize the variety of data available to demonstrate state facility progress.

Replace the HP3000 Servers – One-time state general fund resources totaling $950,000 in FY 2005 are required to replace the Department's HP3000 servers with NT servers. Approximately two years ago, Hewlett Packard stopped the production of HP3000 computers and announced that its maintenance and repair services on HP3000 would be discontinued in 2005. This action jeopardizes the operation of the Department's major financial system, FMS II. FMS II includes a consolidated general ledger module, a cost accounting module, a patient fund accounting module, a budgeting ledger, a purchasing module, and an accounts payable module. Other agency information systems would also be operated on these NT servers, including the QS1

pharmacy system, MP-2 buildings and grounds system, the licensing information system, and the CSB database.

A summary of resource requirements described on the previous pages follows.

Summary of Current Resource Requirements Identified by the Department

Resource Requirement	FY 2005		FY 2006		Biennium Total	
	SGF	NGF	SGF	NGF	SGF	NGF
* Crisis Stabilization	4,331,250	0	5,775,000	0	10,106,250	0
* PACT Teams	2,219,043	0	4,438,086	0	6,657,129	0
* Local Bed Purchases	6,570,000	0	6,570,000	0	13,140,000	0
* Transitional Residential Services	6,690,000	0	10,380,000	0	17,070,000	0
* Consumer/Family Involvement	110,000	0	110,000	0	220,000	0
* State MH Facility Discharge Waiting Lists	4,518,750	0	6,025,000	0	10,543,750	0
* State MR Facility Discharge Waiting Lists	4,187,211	0	3,004,568	0	7,191,779	0
*Community MH Waiting Lists	9,004,600	0	18,549,500	0	27,554,100	0
* Community MR Waiting Lists	9,479,900	0	19,528,600	0	29,008,500	0
* Community SA Waiting Lists	3,419,200	0	7,043,400	0	10,462,600	0
* Medicaid MR Waiver Rate Increase	15,000,000	15,000,000	15,000,000	15,000,000	30,000,000	30,000,000
* Medicaid MR Waiver Urgent Waiting List	11,600,000	11,600,000	23,200,000	23,200,000	34,800,000	34,800,000
Jail-Based MH/SA Services	477,024	0	491,335	0	968,359	0
* Pilot Forensic Residential Programs	481,988	0	500,000	0	981,988	0
Child/Adolescent Service Expansion	4,075,000	0	5,075,000	0	9,150,000	0
Child Psychiatrists & Specialists	3,000,000	0	4,000,000	0	7,000,000	0
Part C Early Intervention Services	3,344,663	0	6,265,363	0	9,610,026	0
MR Services for Children with Complex Needs	675,480	524,520	675,480	524,520	1,350,960	1,049,040
* MI/MR Clinical & Emergency Support Teams	240,000	0	480,000	0	720,000	0

Resource Requirement	FY 2005		FY 2006		Biennium Total	
	SGF	NGF	SGF	NGF	SGF	NGF
* Restructuring SWVTC MI/MR Waiver Slots	425,000	0	425,000	0	850,000	0
* Regional Community Support Centers (Centers of Excellence)	1,000,000	0	1,000,000	0	2,000,000	0
Evidence-Based Practices	385,000	0	660,000	0	1,045,000	0
Behavioral Rehabilitation Center (SVP) Operation	3,746,667	0	5,740,412	0	9,487,079	0
SVP Community Treatment	325,000	0	534,000	0	859,000	0
State MR Facility Staffing	9,317,552	7,235,215	10,249,307	7,958,736	19,566,859	15,193,951
State MH Facility Staffing	1,446,870	142,228	1,591,482	156,823	3,038,352	299,051
State Facility Medications Costs	2,752,246	440,615	3,303,078	528,355	6,055,324	968,970
State Facility Equipment & Vans	584,175	250,362	584,175	250,362	1,168,350	500,724
State Facility Gas & Fuel Costs	670,960	226,250	686,922	238,761	1,357,882	465,011
State Facility Surrogate Decision Makers	90,000	0	40,000	0	130,000	0
State Facility Revenue Shortfall	14,800,000	0	14,800,000	0	29,600,000	0
Nursing Development, Recruitment/Retention	911,667	0	1,335,924	0	2,247,591	0
Terrorism/Disaster Preparedness	172,500	0	172,500	0	345,000	0
CO IT & Facility Operations/Quality Improvement Staff	155,000	0	155,000	0	310,000	0
Replace HP300e Server	950,000	0	0	0	950,000	0
TOTAL	127,158,751	35,421,196	178,391,138	47,859,563	305,545,878	83,276,747

Notes:

* Olmstead-related resource requirements

Non-general funds include anticipated Medicaid and third party payer fees, direct client fees, and other revenues for community services.

VII. CONCLUSION

This document responds to the requirement in §37.1-48.1 of the *Code of Virginia* for a six-year Comprehensive State Plan for mental health, mental retardation, and substance abuse services that identifies the services and supports needs of persons with mental illnesses, mental retardation or alcohol or other drug dependence or abuse problems across the Commonwealth; defines resource requirements; and proposes strategies to address these needs. The directions established in the *Comprehensive State Plan for 2004-2010* would enable the Commonwealth to accelerate the shift to a more completely community-based system of care while preserving the important roles and service responsibilities of state mental health and mental retardation facilities in Virginia's public mental health, mental retardation, and substance abuse services system.

Through its Reinvestment Initiatives and Regional Restructuring Partnerships, the Department and its operational partners continue to emphasize the transition toward a fully community-based system of care where services emphasize each individual's movement toward recovery, self-determination, and integration into life and work in the community, to the extent possible given the nature of his disability and individual circumstances. In this vision for Virginia's future system of community-based services, state mental health and mental retardation facilities will continue to play an important role in this community-based system of care.

The *Comprehensive State Plan for 2004-2010* continues the direction set forth in the *2002-2008 Comprehensive State Plan* to increase community options and individual choice; support opportunities for individual and family member education, training and participation; promote collaborative activities with other agencies and services systems and private sector development; improve services oversight and accountability; advance quality improvement and care coordination; and address system administrative and infrastructure issues.

Given current budget constraints, the policy agenda for publicly funded mental health, mental retardation, and substance abuse services for the next biennium continues to focus, to the extent possible, on two key themes:

- Sustainability of the progress that has been achieved, especially for individuals and family members who have benefited from the expansion and improvement of services during the past four years; and
- Clearly focused growth and development efforts to address, to the extent possible, the critical issues facing Virginia's public mental health, mental retardation, and substance abuse services system.

Appendix A
Prevalence Estimates by CSB

Estimated Prevalence of Serious Mental Illness by CSB and Region

	CSB	Population Age 18 + (2000 Census)	Estimated Ages 18-25	Estimated # Ages 26-49	Estimate # Ages 50+	Total # Ages 18+
I	Harrisonburg-Rockingham	85,277	2,776	2,667	1,362	6,805
	Northwestern	140,392	1,928	5,309	2,779	10,016
	Rappahannock Area	171,192	2,813	7,320	2,670	12,803
	Rappahannock-Rapidan	100,646	1,223	3,877	2,015	7,115
	Region Ten	154,846	3,332	5,600	2,719	11,651
	Rockbridge Area	35,979	686	1,326	653	2,665
	Valley	86,060	1,142	3,124	1,801	6,067
II	Alexandria	106,746	1,744	4,868	1,481	8,093
	Arlington	158,214	2,907	6,998	2,194	12,099
	Fairfax-Falls Church	748,514	10,374	32,343	12,272	54,989
	Loudoun County	119,044	1,346	6,027	1,531	8,904
	Prince William County	227,211	3,928	10,637	2,891	17,456
III	Alleghany Highlands	18,310	216	600	434	1,250
	Blue Ridge	186,564	2,458	6,788	3,902	13,148
	Central Virginia	175,191	2,875	6,176	3,549	12,600
	Cumberland Mountain	80,125	1,153	2,927	1,628	5,708
	Danville-Pittsylvania	84,654	1,111	2,951	1,852	5,914
	Dickenson County	12,776	193	450	266	909
	Highlands	54,335	785	1,848	1,187	3,820
	Mount Rogers	95,805	1,261	3,352	2,087	6,700
	New River Valley	134,770	4,728	4,026	2,126	10,880
	Piedmont	108,920	1,425	3,821	2,371	7,617
	Planning District 1	70,733	1,077	2,455	1,492	5,024
IV	Chesterfield	186,476	2,627	7,998	3,076	13,701
	Crossroads	75,058	1,346	2,580	1,514	5,440
	District 19	126,965	2,061	4,791	2,387	9,239
	Goochland-Powhatan	30,284	337	1,273	553	2,163
	Hanover County	62,957	774	2,597	1,150	4,521
	Henrico Area	213,090	3,015	8,729	3,764	15,508
	Richmond Behavioral Health Author.	154,612	3,464	5,737	2,567	11,768
	Southside	68,668	894	2,370	1,520	4,784
V	Chesapeake	141,901	2,170	6,117	2,250	10,537
	Colonial	96,097	1,671	3,474	1,854	6,999
	Eastern Shore	39,031	526	1,296	888	2,710
	Hampton-Newport News	241,565	5,175	9,595	3,718	18,488
	Middle Peninsula-Northern Neck	103,009	1,101	3,462	2,439	7,002
	Norfolk	178,051	5,519	6,284	2,516	14,319
	Portsmouth	74,711	1,473	2,728	1,352	5,553
	Virginia Beach	308,369	5,751	13,314	4,444	23,509
	Western Tidewater	87,884	1,143	3,434	1,697	6,274
	TOTAL	5,345,032	90,528	211,269	92,951	394,748

Estimated Prevalence of Child/Adolescent Serious Emotional Disturbance by CSB and Region

	CSB	Population Age 9-17 (2000 Census)	Estimated SED
I	Harrisonburg-Rockingham	11,759	1,058
	Northwestern	22,992	2,069
	Rappahannock Area	35,872	3,228
	Rappahannock-Rapidan	17,308	1,558
	Region Ten	22,904	2,061
	Rockbridge Area	4,057	365
	Valley	13,006	1,171
II	Alexandria	10,911	982
	Arlington	16,055	1,445
	Fairfax-Falls Church	130,208	11,719
	Loudoun County	25,694	2,312
	Prince William County	50,699	4,563
III	Alleghany Highlands	2,758	248
	Blue Ridge	27,835	2,505
	Central Virginia	27,446	2,470
	Cumberland Mountain	11,075	997
	Danville-Pittsylvania	13,079	1,177
	Dickenson	1,839	166
	Highlands	7,269	654
	Mount Rogers	13,271	1,194
	New River Valley	15,568	1,401
	Piedmont	15,683	1,411
	Planning District 1	10,396	936
IV	Chesterfield	37,585	3,383
	Crossroads	11,257	1,013
	District 19	20,629	1,857
	Goochland-Powhatan	4,720	425
	Hanover County	12,183	1,096
	Henrico Area	35,524	3,197
	Richmond Behavioral Health Authority	21,719	1,955
	Southside	9,912	892
V	Chesapeake	29,102	2,619
	Colonial	16,294	1,466
	Eastern Shore	6,395	576
	Hampton-Newport News	43,264	3,894
	Middle Peninsula-Northern Neck	15,405	1,386
	Norfolk	28,697	2,583
	Portsmouth	13,068	1,176
	Virginia Beach	59,637	5,367
	Western Tidewater	16,027	1,442
	TOTAL	889,102	80,017

Estimated Prevalence of Mental Retardation by CSB and Region

	CSB	Total 2000 Census	Estimated # Adults (18-64)	Estimated # Children (6-17)	Total Prevalence (Over 6)
I	Harrisonburg-Rockingham	108,193	721	186	1,007
	Northwestern	185,282	1,152	373	1,715
	Rappahannock Area	241,044	1,513	577	2,193
	Rappahannock-Rapidan	134,785	835	289	1,247
	Region Ten	199,648	1,304	368	1,855
	Rockbridge Area	39,072	249	66	367
	Valley	111,524	694	214	1,039
II	Alexandria	128,283	951	147	1,190
	Arlington	189,453	1,405	229	1,773
	Fairfax-Falls Church	1,001,624	6,677	2,030	9,177
	Loudoun County	169,599	1,095	370	1,499
	Prince William County	326,238	2,114	784	2,926
III	Alleghany Highlands	23,518	140	43	219
	Blue Ridge	241,023	1,485	450	2,240
	Central Virginia	228,616	1,421	445	2,123
	Cumberland Mountain	101,884	661	184	955
	Danville-Pittsylvania	110,156	663	214	1,025
	Dickenson	16,395	104	31	154
	Highlands	68,470	429	118	642
	Mount Rogers	121,550	757	214	1,136
	New River Valley	165,146	1,158	246	1,553
	Piedmont	140,039	871	260	1,306
	Planning District 1	91,019	567	169	8,48
IV	Chesterfield	259,903	1,655	625	2,386
	Crossroads	97,103	602	188	907
	District 19	167,129	1,048	339	1,552
	Goochland-Powhatan	39,240	263	76	366
	Hanover County	86,320	538	198	794
	Henrico Area	282,688	1,783	559	2,597
	Richmond BHA	197,790	1,285	341	1,830
	Southside	88,154	538	163	822
V	Chesapeake	199,184	1,241	480	1,819
	Colonial	127,963	801	276	1,191
	Eastern Shore	51,398	154	104	333
	Hampton-Newport News	326,587	2,083	680	2,982
	Middle Peninsula-Northern Neck	133,037	791	260	1,247
	Norfolk	234,403	1,525	440	2,147
	Portsmouth	100,565	609	208	920
	Virginia Beach	425,257	2,724	958	3,882
	Western Tidewater	119,233	730	264	1,098
	TOTAL	7,078,515	45,336	14,166	65,062

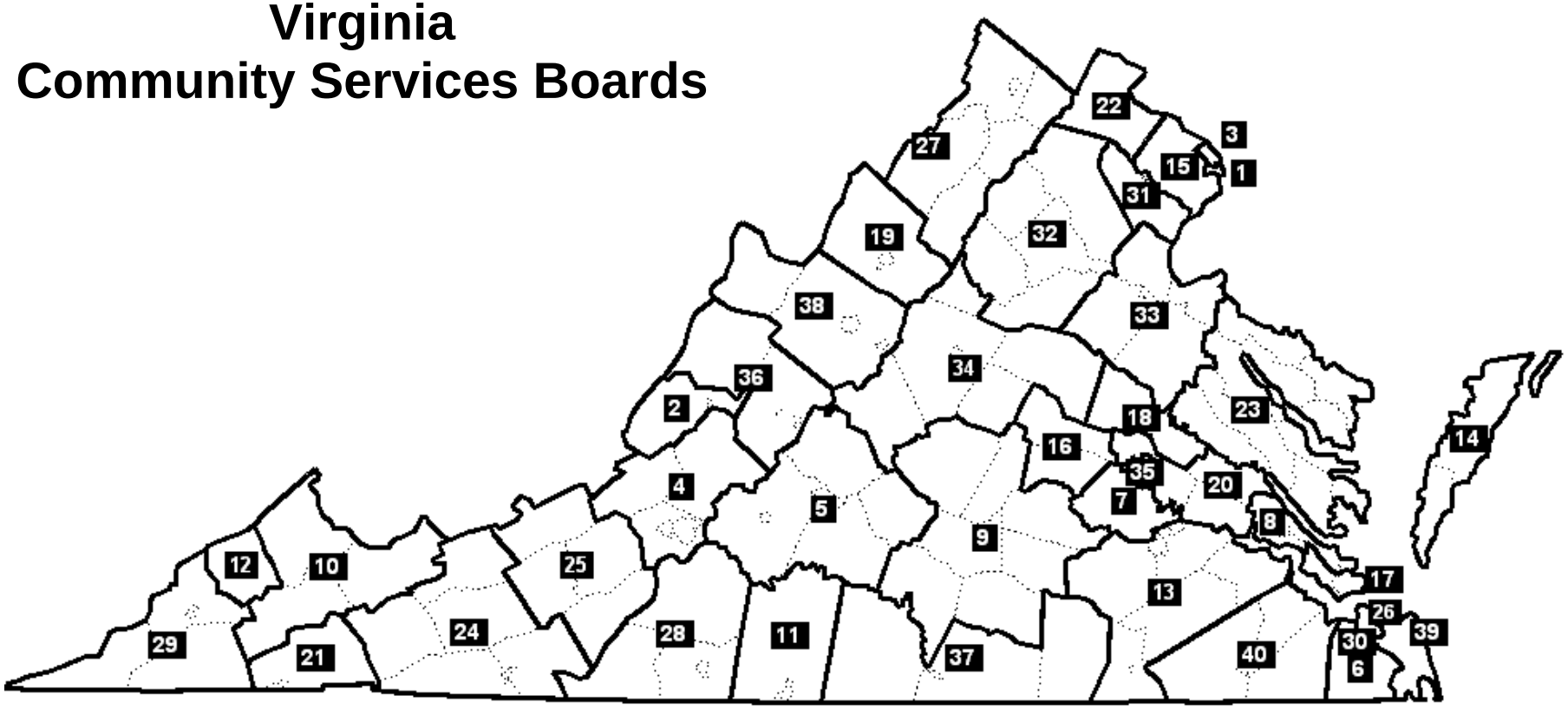
Estimated Prevalence of Substance Dependence by CSB and Region

	CSB	Population 12+ 2000 Census	Estimated # Drug Dependence	Estimated # Alcohol Dependence	Estimated # Drug & Alcohol Depend.
I	Harrisonburg-Rockingham	92,979	1,488	2,231	3,347
	Northwestern	155,664	2,491	3,736	5,604
	Rappahannock Area	194,546	3,113	4,669	7,004
	Rappahannock-Rapidan	112,778	1,804	2,707	4,060
	Region Ten	169,900	2,718	4,078	6,116
	Rockbridge Area	34,057	545	817	1,226
	Valley	95,079	1,521	2,282	3,423
II	Alexandria	112,310	1,797	2,695	4,043
	Arlington	167,118	2,674	4,011	6,016
	Fairfax-Falls Church	831,121	13,298	19,947	29,920
	Loudoun County	132,423	2,119	3,178	4,767
	Prince William County	258,632	4,138	6,207	9,311
III	Alleghany Highlands	20,107	322	483	724
	Blue Ridge	204,923	3,279	4,918	7,377
	Central Virginia	193,723	3,100	4,649	6,974
	Cumberland Mountain	88,143	1,410	2,115	3,173
	Danville-Pittsylvania	93,787	1,501	2,251	3,376
	Dickenson County	14,137	226	339	509
	Highlands	59,317	949	1,424	2,135
	Mount Rogers	104,668	1,675	2,512	3,768
	New River Valley	145,049	2,321	3,481	5,222
	Piedmont	119,914	1,919	2,878	4,317
	Planning District 1	77,955	1,247	1,871	2,806
IV	Chesterfield	212,960	3,407	5,111	7,667
	Crossroads	83,032	1,329	1,993	2,989
	District 19	140,912	2,255	3,382	5,073
	Goochland-Powhatan	33,455	535	803	1,204
	Hanover County	71,182	1,139	1,708	2,563
	Henrico Area	235,406	3,766	5,650	8,475
	Richmond BHA	167,735	2,684	4,026	6,038
	Southside	75,490	1,208	1,812	2,718
V	Chesapeake	161,759	2,588	3,882	5,823
	Colonial	107,863	1,726	2,589	3,883
	Eastern Shore	43,366	694	1,041	1,561
	Hampton-Newport News	268,832	4,301	6,452	9,678
	Middle Peninsula-Nor. Neck	114,208	1,827	2,741	4,111
	Norfolk	195,086	3,121	4,682	7,023
	Portsmouth	83,151	1,330	1,996	2,993
	Virginia Beach	347,317	5,557	8,336	12,503
	Western Tidewater	98,708	1,579	2,369	3,553
	TOTAL	5,918,792	94,701	142,052	213,073

Appendix B

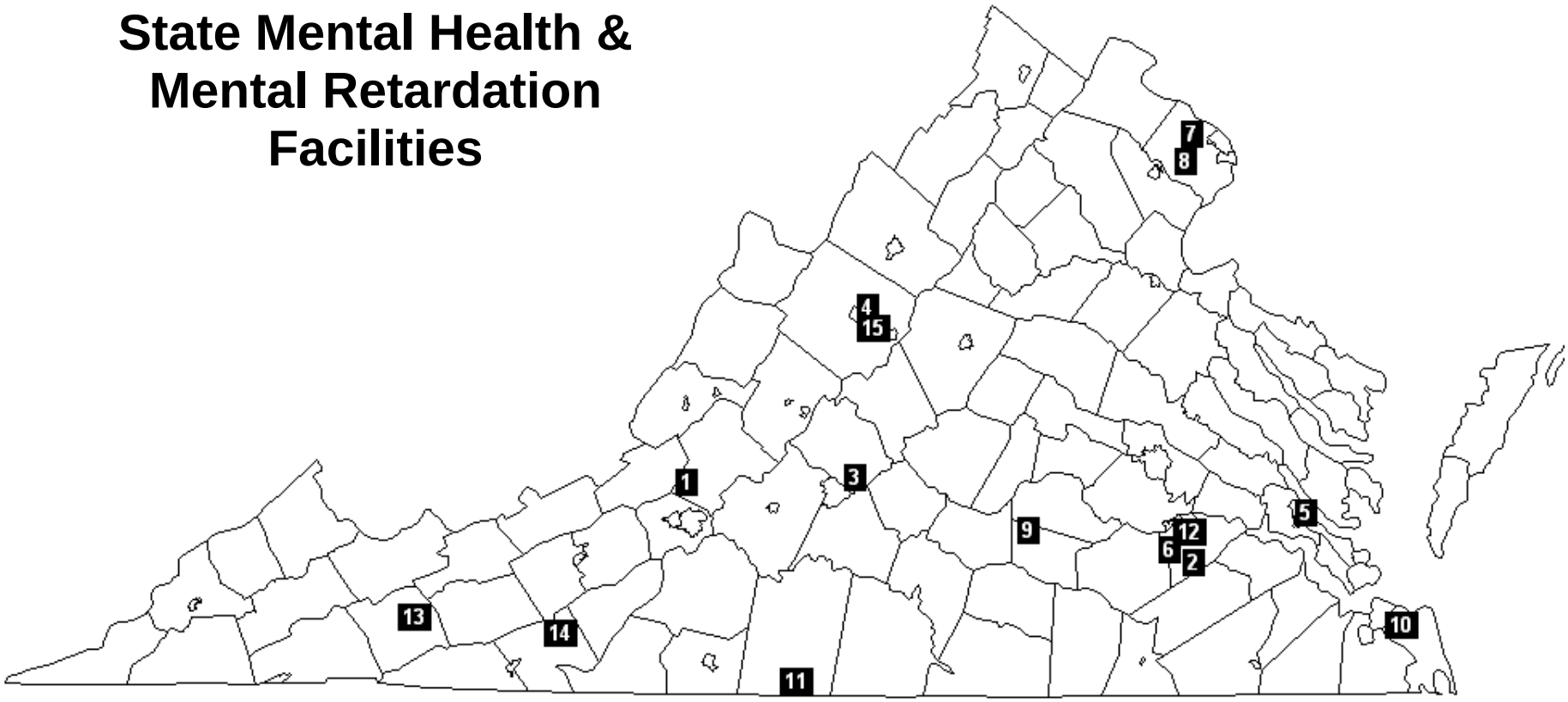
Maps of Community Services Board Service Areas and State Mental Health and Mental Retardation Facility Locations

Virginia
Community Services Boards



1	Alexandria	11	Danville-Pittsylvania	21	Highlands	31	Prince William
2	Alleghany Highlands	12	Dickenson	22	Loudoun	32	Rappahannock-Rapidan
3	Arlington	13	District 19	23	Mid Peninsula-Northern Neck	33	Rappahannock Area
4	Blue Ridge	14	Eastern Shore	24	Mount Rogers	34	Region Ten
5	Central Virginia	15	Fairfax-Falls Church	25	New River Valley	35	Richmond
6	Chesapeake	16	Goochland-Powhatan	26	Norfolk	36	Rockbridge Area
7	Chesterfield	17	Hampton-Newport News	27	Northwestern	37	Southside
8	Colonial	18	Hanover	28	Piedmont	38	Valley
9	Crossroads	19	Harrisonburg-Rockingham	29	Planning District 1	39	Virginia Beach
10	Cumberland Mountain	20	Henrico Area	30	Portsmouth	40	Western Tidewater

State Mental Health & Mental Retardation Facilities



	Facility	Location
1	Catawba Hospital	Catawba
2	Central State Hospital	Petersburg
3	Central VA Training Center	Madison Heights
4	Commonwealth Ctr. for Children & Adolescents	Staunton
5	Eastern State Hospital	Williamsburg
6	Hiram W. Davis Medical Center	Petersburg
7	Northern VA MH Institute	Falls Church
8	Northern VA Training Center	Fairfax

	Facility	Location
9	Piedmont Geriatric Hospital	Burkeville
10	Southeastern VA Training Center	Chesapeake
11	Southern VA Mental Health Institute	Danville
12	Southside VA Training Center	Petersburg
12a	Behavioral Rehabilitation Center	Petersburg
13	Southwestern VA MH Institute	Marion
14	Southwestern VA Training Center	Hillsville
15	Western State Hospital	Staunton

Appendix C
Community Services Board Services Utilization and Condensed Core Services Taxonomy 6 Definitions

Community services boards (CSBs) offer varying combinations of six core services, directly and through contracts with other organizations. Table 1 displays trends in numbers of consumers served between state FY 1986 and 2002 by program area. Tables 2 through 5 display information about static capacities and units of service provided in state FY 2002, which started on July 1, 2001 and ended on June 30, 2002. All tables show actual data, derived from 4th quarter performance reports submitted by CSBs.

Table 1: Consumers Served by Community Services Board[1]

FY	Mental Health		Mental Retardation		Substance Abuse		TOTAL	
	Undupl.[2]	Dupl.[3]	Undupl.[2]	Dupl.[3]	Undupl.[2]	Dupl.[3]	Undupl.[2]	Dupl.[3]
1986	NA	135,182	NA	20,329	NA	52,942	NA	208,453
1987	NA	136,440	NA	22,336	NA	60,169	NA	218,945
1988	110,082	161,033	14,354	22,828	57,363	80,138	181,799	263,999
1989	107,892	157,825	17,361	27,610	62,905	87,878	188,158	273,313
1990	NA	152,811	NA	30,198	NA	101,816	NA	284,825
1991	NA	161,536	NA	28,539	NA	103,288	NA	293,363
1992	NA	160,115	NA	27,525	NA	78,358	NA	265,998
1993	105,389	158,115	19,010	27,696	55,871	80,271	180,270	266,082
1994	107,131	168,208	19,742	28,680	59,471	87,166	186,344	284,054
1995	106,637	177,320	18,572	29,141	61,463	88,471	186,672	294,932
1996	116,344	174,126	19,169	30,006	64,309	90,750	199,822	294,882
1997	115,169	179,500	20,557	30,655	63,040	90,099	198,766	300,254
1998	119,438	185,647	20,983	32,509	68,559	96,556	208,980	314,712
1999	112,729	178,334	21,772	33,087	64,899	93,436	199,400	304,857
2000	118,210	180,783	22,036	26,086	61,361	88,358	201,607	295,227
2001	105,169	178,254	23,843	33,238	59,968	102,037	188,980	313,529
2002	107,351	176,735	24,903	33,933	59,895	91,904	192,149	302,572

NOTES:

1. Unduplicated counts of consumers were not collected by the Department every year. The NA notations show years in which this information was not collected.
2. Unduplicated (**Undupl.**) numbers of individuals are the total number of consumers receiving services in a program (mental health, mental retardation, and substance abuse services) area, regardless of how many services they received. If a person with a dual diagnosis (e.g., mental illness and substance abuse) received services in both program areas, he would be counted twice.
3. Duplicated (**Dupl.**) numbers of individuals are the total numbers of consumers receiving each category or subcategory of core services. Thus, if a person received outpatient, rehabilitation, and supervised residential services, he would be counted three times, since he received three services. These totals are added to calculate a total number for each program area.

Table 2: FY 2002 CSB MH Static Capacities by Service

Service	Capacity	Service	Capacity
Day Treatment/Partial Hospitalization	102.16 slots	Local Inpatient	39.87 beds
Therapeutic Day Treatment - C&A	440.25 slots	TOTAL Local Inpatient	39.87 beds
Rehabilitation Services	2,130.00 slots	Highly Intensive Residential	45.00 beds
Sheltered Employment Services	34.00 slots	Intensive Residential	120.00 beds
Supported Employment - Group Models	14.00 slots	Supervised Residential	680.63 beds
TOTAL Day Support Services	2,720.41 slots	TOTAL Residential Services	845.63 beds

Note: Decimal fractions of beds and slots result from calculating these capacities for contracted services where a CSB purchases a number of bed days or days of service, which must be converted to numbers of beds or day support slots.

Table 3: FY 2002 MR CSB Static Capacities by Service

Service	Capacity	Service	Capacity
Rehabilitation Services	434.30 slots	Highly Intensive Residential	58.00 beds
Sheltered Employment Services	952.00 slots	Intensive Residential	228.50 beds
Supported Employment - Group Models	528.70 slots	Supervised Residential	194.75 beds
TOTAL Day Support Services	1,915.00 slots	TOTAL Residential Services	481.25 beds

Note: Decimal fractions of beds and slots result from calculating these capacities for contracted services where a CSB purchases a number of bed days or days of service, which must be converted to numbers of beds or day support slots.

Table 4: FY 2002 SA CSB Static Capacities by Service

Service	Capacity	Service	Capacity
Local Inpatient	1.37 beds	Highly Intensive Residential	149.33 beds
Community Hospital-Based Detox	19.34 beds	Intensive Residential	684.62 beds
TOTAL Local Inpatient	20.71 beds	Jail-Based Habilitation	197.53 beds
Day Treatment/Partial Hospitalization	382.39 slots	Supervised Residential	107.22 beds
TOTAL Day Support Services	382.39 slots	TOTAL Residential Services	1,138.70 beds

Note: Decimal fractions of beds and slots result from calculating these capacities for contracted services where a CSB purchases a number of bed days or days of service, which must be converted to numbers of beds or day support slots.

Table 5: Units of Community Services Board Services Provided in FY 2002 by Core Service

Program Area Core Service/Unit of Service	Mental Health	Mental Retardation	Substance Abuse	TOTAL
Emergency Consumer Service Hours	331,987		62,453	394,440
Local Inpatient Services	6,779		194	6,973
Community Hospital-Based Detox			1,021	1,021
TOTAL Local Inpatient Service Bed Days	6,779		1,215	7,994
Outpatient Services	699,478	2,213	556,464	1,258,155
Intensive In-Home Services	239,717			239,717
Motivational Treatment Services			2,793	2,793
Case Management	777,103	270,343	199,758	1,247,204
Assertive Community Treatment	24,235			24,235
Methadone Detoxification Services			29,126	29,126
Opioid Replacement Therapy Services			83,479	83,479
Consumer Monitoring Services		6,170		6,170
TOTAL OP & CM Cons. Service Hours	1,740,533	278,726	871,620	2,890,879
Day Treatment/Partial Hospitalization	98,569		328,372	426,941
Therapeutic Day Treatment - C&A	274,360			274,360
Rehabilitation Services	2,590,593	462,640		3,053,233
TOTAL Day Support Hours	2,963,522	462,640	328,372	3,754,534
Sheltered Employment Services	13,787	192,974		206,761
Supported Employment - Group Models	5,567	101,278		106,845
TOTAL Day Support Days of Service	19,354	294,252		313,606
Supported/Transitional Employment	32,035	111,039		143,074
Alternative Day Support Arrangements	8,056	44,409	2,377	54,842
TOTAL Day Support Cons. Service Hours	40,091	155,448	2,377	197,916
Highly Intensive Residential Services	10,509	18,203	39,430	68,142
Intensive Residential Services	33,346	71,743	168,009	273,098
Jail-Based Habilitation Services			61,000	61,000
Supervised Residential Services	209,349	61,475	33,497	304,321
TOTAL Residential Bed Days	253,204	151,421	301,936	706,561
Supportive Residential Services	190,606	178,939	18,649	388,194
TOTAL Residential Cons. Service Hours	190,606	178,939	18,649	388,194
Prevention Services	23,409	4,977	315,147	343,533
Early Intervention Services	8,248	251,472	26,935	286,655
TOTAL Prev. & E.I. Cons. Service Hours	31,657	256,449	342,082	630,188

CONDENSED CORE SERVICES TAXONOMY 6 DEFINITIONS

EMERGENCY SERVICES are unscheduled, and in some instances scheduled (e.g., crisis stabilization), mental health, mental retardation, or substance abuse services, available 24 hours per day and seven days per week, that provide crisis intervention, stabilization, and referral assistance over the telephone or face-to-face, if indicated, to individuals seeking such services for themselves or others. Emergency services may include walk-ins, home visits, jail interventions, and pre-admission screenings and other activities for the prevention of institutionalization or associated with the judicial commitment process.

LOCAL INPATIENT SERVICES deliver mental health or substance abuse services on a 24 hour per day basis in a hospital setting.

- ***Acute Psychiatric or Substance Abuse*** services provide intensive short term psychiatric treatment, including services to persons with mental retardation, or substance abuse treatment, except for detoxification, in local hospitals through contractual arrangements. These services may include intensive stabilization, evaluation, chemotherapy, psychiatric and psychological services, and other supportive therapies provided in a highly structured and supervised setting.
- ***Community-Based Substance Abuse Medical Detoxification*** services use medication under the supervision of medical personnel to systematically eliminate or reduce effects of alcohol or other drugs in the body in local hospitals or other 24 hour care facilities.

OUTPATIENT AND CASE MANAGEMENT SERVICES provide mental health, mental retardation or substance abuse services, generally in sessions of less than three consecutive hours, to individuals in a non-residential setting.

- ***Outpatient*** services are generally provided to consumers on an hourly schedule, on an individual, group, or family basis. Outpatient services may include diagnosis and evaluation, intake and screening, counseling, psychotherapy, behavior management, psychological testing and assessment, and medication services, which include prescribing and dispensing medications and medication management.
- ***Intensive In-home*** services are time-limited (usually between two and six months) family preservation interventions for children and adolescents with or at risk of serious emotional disturbance, including such individuals who also have a diagnosis of mental retardation. In-home services are provided typically but not solely in the residence of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement. These services provide crisis treatment; individual and family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and 24 hour per day emergency response.
- ***Methadone Detoxification*** services combine outpatient treatment with the administering or dispensing of methadone as a substitute narcotic drug in decreasing doses to reach a drug free state in a period not to exceed 180 days.
- ***Methadone Maintenance*** services combine outpatient treatment with the administering or dispensing of methadone as a substitute narcotic drug at relatively stable dosage levels for a period in excess of 180 days.
- ***Case Management*** services assist individuals and their family members in accessing needed services that are responsive to individual needs. Services include: identifying and reaching out to potential consumers; assessing needs and planning services; linking the individual to services and supports; assisting the person directly to locate, develop or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; and advocating for people in response to their changing needs.

DAY SUPPORT SERVICES provide structured programs of treatment, activity, or training services, generally in clusters of two or more continuous hours per day, to groups or individuals in a non-residential setting.

- ***Day Treatment/Partial Hospitalization*** is a treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational and educational treatment modalities designed for adults with serious mental or alcohol or other drug abuse disorders who require coordinated, intensive, comprehensive, and multi-disciplinary treatment of pathological conditions that is not provided in outpatient services.
- ***Therapeutic Day Treatment for Children and Adolescents*** is a treatment program that serves children and adolescents (ages 0 through 17) with serious emotional disturbances or children at risk (ages 0 through 6) of serious emotional disturbance in order to combine psychotherapeutic interventions with education and mental health treatment. Services include: evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills; and individual, group, and family counseling.
- ***Rehabilitation*** programs include a variety of training opportunities in two modalities.

  Psychosocial rehabilitation programs provide certain basic opportunities and services - assessment, medication education, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support and education, vocational and educational opportunities, and advocacy - in a supportive environment in the community focusing on normalization. Psychosocial rehabilitation emphasizes strengthening the person's abilities to deal with everyday life rather than focusing on treating pathological conditions.

  Day Health and Rehabilitation programs provide planned combinations of individualized activities, supports, training, supervision, and transportation to people with mental retardation to improve their condition or to maintain an optimal level of functioning as well as to ameliorate the individual's disabilities or deficits by reducing the degree of impairment or dependency. Specific components of this service develop or enhance the following skills: self care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, and medication management, and transportation.
- ***Sheltered Employment or Work Activity*** programs provide work in a non-integrated setting that is compensated in accordance with the Fair Labor Standards Act for individuals with disabilities who are not ready, are unable, or choose not to enter into competitive employment in an integrated setting. This service also includes the development of social, personal, and work-related skills based on an individualized consumer service plan.
- ***Supported Employment-Group Model*** programs provide work to a small group (three to eight people) of individuals at a job site in the community or at dispersed sites within an integrated setting. Integrated setting means opportunities exist for consumers in the immediate work setting for regular contact with non-disabled individuals who are not providing support services. The consumers may be employed by the employer or by the vendor of supported employment services. Ongoing support services are provided by an employment specialist who may be employed by the employer or by the vendor. Models include mobile and stationary crews, enclaves, and small businesses (entrepreneurial).
- ***Supported Employment*** programs provide work to a single consumer placed in an integrated work setting in the community. The consumer is employed by the employer. On-going support services that may include transportation, job-site training, counseling, advocacy, and any other supports needed to achieve and to maintain the consumer in the supported placement are provided by an employment specialist, co-workers of the supported employee, or other qualified individuals.

- ***Alternative Day Support Arrangements*** are day support alternatives not included in the preceding subcategories. They assist people to locate day support settings and may provide program staff, follow along, or assistance to these individuals. The focus may be on assisting the person to maintain an independent day support arrangement. This subcategory also includes *Education/Recreation* services providing education, recreation, enrichment, and leisure activities daily, weekly, or monthly, during the summer or throughout the year.

RESIDENTIAL SERVICES provide overnight care in conjunction with an intensive treatment or training program in a setting other than a hospital or training center or overnight care in conjunction with supervised living or other supportive residential services.

- ***Highly Intensive Residential Services*** provide overnight care in conjunction with intensive treatment or training services. These services include: Mental Health Residential Treatment Centers such as short term intermediate care, crisis stabilization, residential alternatives to hospitalization, and dually diagnosed programs where intensive treatment rather than just supervision occurs; Intermediate Care Facilities for Mentally Retarded persons (ICF/MR) that deliver active habilitative and training services in a ***community*** setting; and Social Detoxification Programs that systematically reduce or eliminate the effects of alcohol or other drugs in the body (returning the person to a drug-free state) in a *specialized non-medical facility* with physician services available when required and normally last up to seven days.

- ***Intensive Residential Services*** provide overnight care in conjunction with treatment or training that is less intense than the first subcategory and include the following types of services.

  Primary Care offers substance abuse rehabilitation services that normally last no more than 30 days. Services include intensive stabilization, daily group therapy and psychoeducation, consumer monitoring, case management, individual and family therapy, and discharge planning.

  Intermediate Rehabilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay up to 90 days. Services include supportive group therapy, psychoeducation, consumer monitoring, case management, individual and family therapy, employment services, and community preparation services.

  Long-Term Habilitation is a substance abuse psychosocial therapeutic milieu with an expected stay of 90 or more days that provides a highly structured environment where residents, under staff supervision, are responsible for daily operations of the facility. Services include intensive daily group and individual therapy, family counseling, and psychoeducation. Daily living skills and employment opportunities are integral components of the treatment program.

  Group Homes/Halfway Houses are facilities of five or more beds that provide identified beds, supported or controlled by CSBs, and 24 hour supervision for individuals who require training and assistance in basic daily living functions such as meal preparation, personal hygiene, transportation, recreation, laundry, and budgeting. The expected length of stay normally exceeds 30 days.

- ***Supervised Residential Services*** offer overnight care in conjunction with supervision and services and include the following types of services.

  Supervised Apartments are directly-operated or contractual, licensed or unlicensed, residential programs that place and provide services to individuals in units that are owned, rented, leased, or otherwise controlled by the licensed service provider. The length of stay normally exceeds 30 days.

  Domiciliary Care provides food, shelter, and assistance in routine daily living but not treatment or training in facilities of five or more beds. This is primarily a long-term setting with an expected length of stay exceeding 30 days. Domiciliary care is a less intensive program than a group home or supervised apartment; an example would be a licensed adult care residence

funded by a community services board.

Emergency Shelter/Residential Respite programs provide identified beds, supported or controlled by CSBs, in a variety of settings reserved for short term stays, usually several days to no more than 21 consecutive days.

Sponsored Placements place people in residential settings and provide substantial amounts of financial, programmatic, or service support. Examples include individualized therapeutic homes, specialized foster care, family sponsor homes, and residential services contracts for specified individuals. The focus is on individual consumer residential placements with an expected stay exceeding 30 days.

- ***Supportive Residential Services*** are unstructured services that support individuals in their own housing arrangements. These services normally do not involve overnight care delivered by a program. However, due to the flexible nature of these services, overnight care may be provided on an **hourly** basis.

  In-Home Respite provides care in the homes of people with mental disabilities or in a setting other than that described in residential respite services above. This care may last from several hours to several days and allows the family member care giver to be absent from the home.

  Supported Living Arrangements are residential alternatives not included in other types of residential services. They assist people to locate or maintain residential settings where access to beds is not controlled by CSBs and may provide program staff, follow along, or assistance to the person. The focus may be on assisting the individual to maintain an independent residential arrangement. Examples include homemaker services, public-private partnerships, PATH grant outreach and support services, and non-CSB subsidized apartments (e.g., HUD certificates).

- ***Family Support*** offers assistance for families who choose to provide care at home for family members with mental disabilities. Family support is a combination of financial assistance, services, and technical supports that allows families to have control over their lives and the lives of their family members. The support should be flexible and individualized to meet the unique needs of the family and the individual with the disability. Family support services may include respite care, adaptive equipment, personal care supplies and equipment, behavior management, minor home adaptation or modification, day care, and other extraordinary needs.

PREVENTION AND EARLY INTERVENTION SERVICES are designed to prevent or intervene early in the process of mental illness, mental retardation, or substance abuse.

Prevention services involve people, families, communities, and systems working together to promote their strengths and potentials. Prevention is aimed at substantially reducing the incidence of mental illness, mental retardation and other developmental disabilities, and alcohol and other drug dependency and abuse. The emphasis is on the enhancement of protective factors and the reduction of risk factors. *Information Dissemination* provides awareness and knowledge of the nature and extent of mental illness, mental retardation, and alcohol and other drug dependency and abuse. *Prevention Education* aims to affect critical life and social skills, including general competency building, specific coping skills training, support system interventions, strengthening caregivers, and decision-making skills training. *Alternatives* provide for the participation of specific populations in activities that are constructive, promote healthy choices, and provide opportunities for skill building. *Problem Identification and Referral* aims at the identification of those individuals who are most at risk of developing problematic behaviors in order to assess if their behaviors can be changed though prevention education. *Community-based Process* aims at enhancing the ability of the community to more effectively provide prevention and treatment services. *Environmental* prevention programs and activities establish or change written and unwritten community standards, codes, and attitudes, thereby influencing the development of healthy living conditions.

- ***Early Intervention*** services are intended to improve functioning or change behavior in those people identified as beginning to experience problems, symptoms, or behaviors which without intervention are likely to result in the need for treatment. Early intervention services are generally targeted to identified individuals or groups. Examples of early intervention services may include: case consultation, groups for adolescents who have been suspended for use of alcohol or tobacco, and programs for children or adults exhibiting behavior changes following loss such as divorce, death of a loved one, and job loss.

  Early Intervention includes *Infant and Toddler Intervention*, which provides family-centered, community-based early intervention services designed to meet the developmental needs of infants and toddlers and the needs of their families as these needs relate to enhancing the child's development. These services also prevent or minimize the potential of developmental delays and increase the capacity of families to meet the needs of their at-risk infants and toddlers. Infant and toddler intervention is delivered through a comprehensive, coordinated, interagency, and multi-disciplinary services system. Infant and toddler intervention includes: audiology, family training, counseling and home visits, health, medical, nursing, nutrition, occupational therapy, physical therapy, psychological, special instruction, speech-language pathology, vision, and transportation services.

DEFINITIONS OF STATIC CAPACITIES

Number of Beds: the total number of beds for which the facility or program is licensed and staffed or the number of beds contracted for during the contract period.

Number of Slots: the maximum number of distinct consumers who could be served during a day or a half-day session in most day support programs. It is the number of slots for which the program or service is staffed.

Consumers: the number of consumers will always be the total number of consumers served during the reporting period. The following definitions are used to determine at what point in time an individual is counted as a consumer.

- **Emergency**: upon documented face-to-face contact or telephone contacts during which a person receives counseling.
- **Inpatient:** upon physical residence in the program.
- **Outpatient and Case Management:** upon initial documented face-to-face contact for people for whom a record would normally be opened. For case management services, face-to-face contact is not necessary if records are obtained, a file is opened, and extensive preliminary work is done for a consumer before it is feasible to meet the consumer in a face-to-face situation.
- **Day Support:** upon initial documented attendance or participation in the program, or, for supported employment and alternative day support, upon initial documented face-to-face contact for persons for whom a record would normally be opened.
- **Residential:** upon physical residence in the program, or, for supported services, upon initial documented face-to-face contact for individuals for whom a record would normally be opened.
- **Early Intervention:** upon initial documented attendance or participation in early intervention programs, including infant and toddler intervention.

Appendix D
State Mental Health and Mental Retardation Facility Utilization

State Mental Health Facility Patients Served, Average Daily Census, Admissions, and Separations -- FY 2003

MH Facility	# Patients Served*	Average Daily Census	# Admissions	# Separations
Eastern State Hospital	1,509	486	1,267	1,278
Western State Hospital	1,002	252	844	838
Central State Hospital	782	280	553	572
Southwest VA MHI	1,130	147	1,204	1,216
Northern VA MHI	507	120	457	456
Southern VA MHI	375	76	362	366
Commonwealth Center for Children and Adolescents	463	35	486	481
Catawba Hospital	634	93	701	718
Piedmont Geriatric Hospital	202	122	72	83
Hiram Davis Medical Center	286	71	264	260
Total MH	6,890	1,680	6,210	6,268

State Mental Retardation Training Center Residents Served, Average Daily Census, Admissions, and Separations -- FY2003

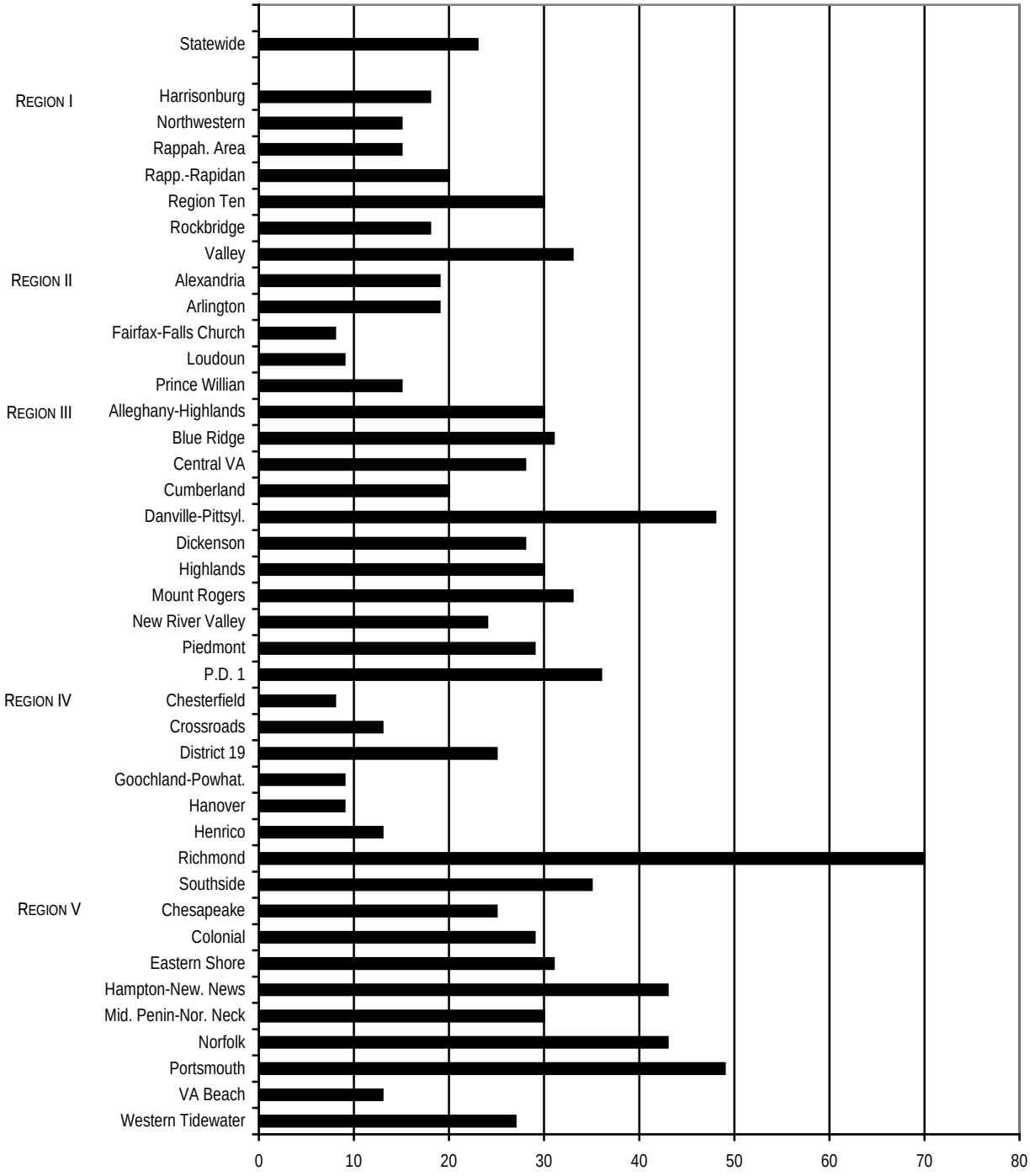
MR Training Center	#Residents Served*	Average Daily Census	# Admissions	# Separations
Central Virginia TC	664	606	16	44
Northern Virginia TC	208	185	44	45
Southeastern Virginia TC	207	191	16	10
Southside Virginia TC	414	387	10	23
Southwestern Virginia TC	224	212	9	10
Total MR	1,717	1,581	95	132

Source: Patient Resident Automated Information System
* Unduplicated Count

Total State Mental Health Facility Bed Utilization by CSB and Region

FY 2002

Beds Per 100,000 Population

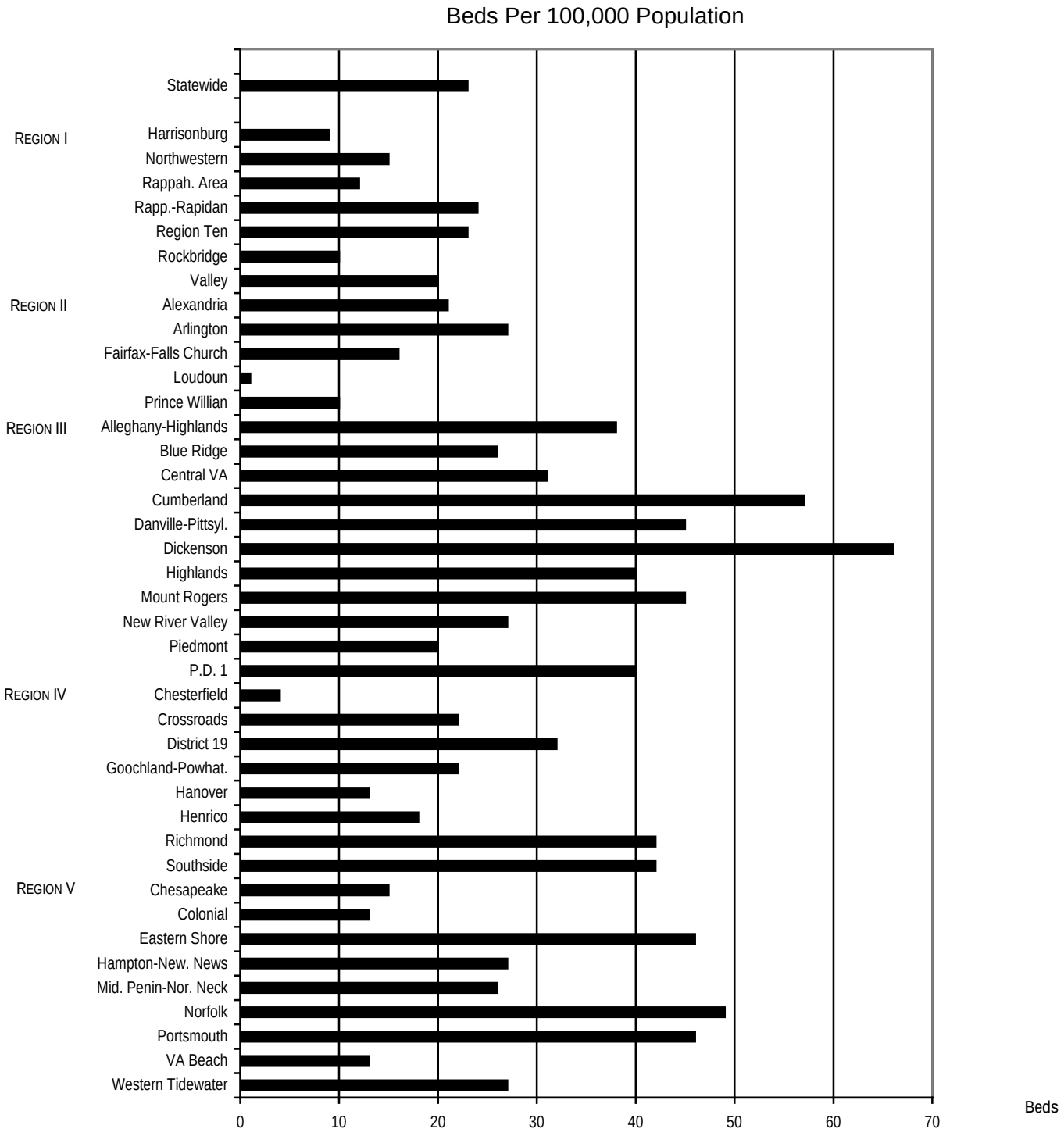


Total State Mental Health Facility Utilization by CSB and Region -- FY2002

	CSB	All Bed Days FY 2002	Population	FY 2002 Bed Days Per 100 K Population	FY 2002 Beds Per 100 K Population	Beds Used
I	Harrisonburg-Rockingham	7,130	108,193	6,590	18.06	19.53
	Northwestern	10,354	185,282	5,588	15.31	28.37
	Rappahannock Area	13,102	241,044	5,436	14.89	35.90
	Rappahannock-Rapidan	10.040	134,785	7,449	20.41	27.51
	Region Ten	21,774	199,648	10,906	29.88	59.65
	Rockbridge Area	2,499	39,072	6,396	17.52	6.85
	Valley	13,372	111,524	11,990	32.85	36.64
II	Alexandria	8,880	128,283	6,922	18.96	24.33
	Arlington	13,104	189,453	6,917	18.95	35.90
	Fairfax-Falls Church	30,081	1,001,624	3,003	8.23	82.41
	Loudoun County	5,465	169,599	3,222	8.83	14.97
	Prince William County	17,831	326,238	5,466	14.97	48.85
III	Alleghany Highlands	2,523	23,518	10,728	29.39	6.91
	Blue Ridge	27,235	241,023	11,300	30.96	74.62
	Central Virginia	23,266	228,616	10,177	27.88	63.74
	Cumberland Mountain	7,523	101,884	7,384	20.23	20.61
	Danville-Pittsylvania	19,279	110,156	17,502	47.95	52.82
	Dickenson County	1,699	16,395	10,363	28.39	4.65
	Highlands	7,397	68,470	10,803	29.60	20.27
	Mount Rogers	14,785	121,550	12,081	33.10	40.23
	New River Valley	14,565	165,146	8,819	24.16	39.90
	Piedmont	14,777	140,039	10,552	28.91	40.48
	Planning District 1	11,809	91,019	12,974	35.55	32.35
IV	Chesterfield	7,911	259,903	3,044	8.34	21.67
	Crossroads	4,605	97,103	4,742	12.99	12.62
	District 19	14,971	167,129	8,958	24.54	41.02
	Goochland-Powhatan	1,233	39,240	3,142	8.61	3.38
	Hanover County	2,702	86,320	3,130	8.58	7.40
	Henrico Area	13,357	282,688	4,725	12.95	36.59
	Richmond BHA	50,724	197,790	25,645	70.26	138.97
	Southside	11,109	88,154	12,602	34.53	30.44
V	Chesapeake	18,191	199,184	9,133	25.02	49.84
	Colonial	13,393	127,963	10,466	28.67	36.69
	Eastern Shore	5,804	51,398	11,292	30.94	15.90
	Hampton-Newport News	51,010	326,587	15,619	42.79	139.75
	Middle Peninsula-Northern Neck	14,555	133,037	10,941	29.97	39.88
	Norfolk	36,910	234,403	15,746	43.14	101.12
	Portsmouth	18,086	100,565	17,984	49.27	49.55
	Virginia Beach	20,570	425,257	4,837	13.25	56.36
	Western Tidewater	11,846	119,233	9,935	27.22	32.45
Out of State		8,192	--	--	--	22.44
	VIRGINIA STATEWIDE	603,559	7,078,515	8,527	23.36	1,653.59

Source: DMHMRSAS PRAIS System and 2000 Census

Mental Retardation Training Center Bed Utilization by CSB and Region
FY 2002



State Training Center Utilization by CSB and Region -- FY 2002

	CSB	All Bed Days FY 2002	Population	FY 2002 Bed Days Per 100 K Population	FY 2002 Beds Per 100 K Population	Beds Used
I	Harrisonburg-Rockingham	3,626	108,193	3,351	9.18	9.93
	Northwestern	10,221	185,282	5,516	15.11	28.00
	Rappahannock Area	10,421	241,044	4,323	11.84	28.55
	Rappahannock-Rapidan	11,976	134,785	8,885	24.34	32.81
	Region Ten	16,806	199,648	8,418	23.06	46.04
	Rockbridge Area	1,460	39,072	3,737	10.24	4.00
	Valley	8,125	111,524	7,285	19.96	22.26
II	Alexandria	9,728	128,283	7,583	20.78	26.65
	Arlington	18,956	189,453	10,006	27.41	51.93
	Fairfax-Falls Church	59,131	1,001,624	5,904	16.17	162.00
	Loudoun County	730	169,599	430	1.18	2.00
	Prince William County	11,980	326,238	3,672	10.06	32.82
III	Alleghany Highlands	3,281	23,518	13,951	38.22	8.99
	Blue Ridge	23,146	241,023	9,603	26.31	63.41
	Central Virginia	25,981	228,616	11,364	31.14	71.18
	Cumberland Mountain	21,100	101,884	20,710	56.74	57.81
	Danville-Pittsylvania	17,969	110,156	16,312	44.69	49.23
	Dickenson County	3,948	16,395	24,081	65.97	10.82
	Highlands	10,104	68,470	14,757	40.43	27.68
	Mount Rogers	20,132	121,550	16,563	45.38	55.16
	New River Valley	16,492	165,146	9,986	27.36	45.18
	Piedmont	10,214	140,039	7,294	19.98	27.98
	Planning District 1	13,303	91,019	14,616	40.04	36.45
IV	Chesterfield	4,138	259,903	1,592	4.36	11.34
	Crossroads	7,884	97,103	8,119	22.24	21.60
	District 19	19,710	282,688	11,793	32.31	54.00
	Goochland-Powhatan	3,204	167,129	8,165	22.37	8.78
	Hanover County	4,002	39,240	4,636	12.70	10.96
	Henrico Area	18,870	86,320	6,675	18.29	51.70
	Richmond BHA	30,196	197,790	15,267	41.83	82.73
	Southside	13,441	88,154	15,247	41.77	36.82
V	Chesapeake	10,654	199,184	5,349	14.65	29.19
	Colonial	6,055	127,963	4,732	12.96	16.59
	Eastern Shore	8,565	51,398	16,664	45.65	23.47
	Hampton-Newport News	31,729	326,587	9,715	26.62	86.93
	Middle Peninsula-Northern Neck	12,511	133,037	9,404	25.76	34.28
	Norfolk	42,181	234,403	17,995	49.30	115.56
	Portsmouth	16,836	100,565	16,741	45.87	46.13
	Virginia Beach	19,562	425,257	4,600	12.60	53.59
	Western Tidewater	11,874	119,233	9,959	27.28	32.53
Out of State		416	--	--	--	1.14
	VIRGINIA STATEWIDE	590,658	7,078,515	8,344	22.86	1,618.24

Source: DMHMRSAS PRAIS System and 2000 Census

State Mental Health and Mental Retardation Facility Numbers of Admissions, Separations and Average Daily Census
FY 1976 to FY 2003

	State Mental Health Facilities*			State Mental Retardation Training Centers**		
	Number of Admissions	Number of Separations	Average Daily Census	Number of Admissions	Number of Separations	Average Daily Census
FY 1976	10,319	10,943	5,967	250	639	4,293
FY 1977	10,051	10,895	5,489	418	618	3,893
FY 1978	10,641	11,083	5,218	277	404	3,790
FY 1979	10,756	10,926	5,112	299	416	3,701
FY 1980	10,513	11,345	4,835	296	428	3,576
FY 1981	10,680	11,513	4,486	252	399	3,467
FY 1982	10,212	10,616	4,165	205	301	3,391
FY 1983	10,030	10,273	3,798	162	232	3,309
FY 1984	9,853	10,163	3,576	194	322	3,189
FY 1985	9,456	9,768	3,279	197	314	3,069
FY 1986	8,942	9,077	3,110	172	280	2,970
FY 1987	8,919	8,900	3,004	165	238	2,892
FY 1988	9,549	9,637	3,047	143	224	2,828
FY 1989	9,591	9,605	3,072	146	231	2,761
FY 1990	9,249	9,293	2,956	110	181	2,676
FY 1991	9,323	9,519	2,904	107	162	2,626
FY 1992	9,057	9,245	2,775	116	215	2,548
FY 1993	8,560	8,651	2,588	94	192	2,481
FY 1994	9,187	9,317	2,482	106	193	2,375
FY 1995	8,550	8,774	2,348	87	216	2,249
FY 1996	7,468	7,529	2,222	87	223	2,132
FY 1997	7,195	7,257	2,118	77	210	1,987
FY 1998	7,431	7,522	2,089	78	170	1,890
FY 1999	6,210	6,449	1,914	106	188	1,812
FY 2000	5,069	5,233	1,694	101	194	1,749
FY 2001	5,223	5,176	1,641	101	156	1,680
FY 2002	5,936	5,915	1,654	122	177	1,618
FY 2003	5,946	6,008	1,609	95	132	1,581

* Excludes Hiram Davis Medical Center. Includes the Virginia Treatment Center for Children (VTCC) through FY 91 when the VTCC was transferred to MCV.

** Operations at SVTC began in 1971, NVTC began in 1973, SWVTC in 1973, and SEVTC began in 1975.

Appendix E
Individuals on Waiting Lists for CSB Services by CSB
Numbers of Adults on CSB Mental Health Services Waiting Lists on April 11, 2003

	CSB	Est. Prevalence Adult SMI	Unduplicated Numbers from FY 2002 4th Quarter Report		On CSB Waiting Lists		Total on CSB Waiting List
			# Served	# SMI	Receiving CSB Services	Not Receiving Some CSB Services	
I	Harrisonburg-Rockingham	6,805	1,449	923	104	1	105
	Northwestern	10,016	2,691	1,216	263	7	270
	Rappahannock Area	12,803	2,420	1,094	79	23	102
	Rappahannock-Rapidan	7,115	2,734	1,102	222	4	226
	Region Ten	11,651	2,066	940	4	9	13
	Rockbridge	2,665	927	354	25	0	25
	Valley	6,067	1,606	774	84	1	85
II	Alexandria	8,093	2,076	923	30	23	53
	Arlington	12,099	2,033	1,050	78	1	79
	Fairfax-Falls Church	54,989	9,134	2,836	541	138	679
	Loudoun	8,904	1,993	665	26	10	36
	Prince William	17,456	3,536	1,200	50	62	112
III	Alleghany-Highlands	1,250	693	354	19	3	22
	Blue Ridge	13,148	1,624	1,624	218	30	248
	Central Virginia	12,600	1,579	1,579	8	0	8
	Cumberland Mountain	5,708	1,672	997	214	13	227
	Danville-Pittsylvania	5,914	1,542	722	85	27	112
	Dickenson County	909	551	415	0	0	0
	Highlands	3,820	1,831	861	0	0	0
	Mount Rogers	6,700	2,344	1,980	618	27	645
	New River Valley	10,880	1,884	1,067	30	22	52
	Piedmont Regional	7,617	2,497	1,043	36	4	40
	P.D. 1	5,024	1,246	992	108	0	108
IV	Chesterfield	13,701	1,500	855	138	32	170
	Crossroads	5,440	1,581	905	52	2	54
	District 19	9,239	2,249	727	30	11	41
	Goochland-Powhatan	2,163	346	185	26	1	27
	Hanover	4,521	1,643	404	174	0	174
	Henrico	15,508	3,192	1,567	521	32	553
	Richmond BHA	11,768	4,839	1,912	219	4	223
	Southside	4,784	1,360	795	4	2	6
V	Chesapeake	10,537	1,618	838	32	46	78
	Colonial	6,999	1,823	698	32	0	32
	Eastern Shore	2,710	1,059	536	0	0	0
	Hampton-Newport News	18,488	4,288	2,425	40	4	44
	Middle Pen.-Northern Neck	7,002	1,706	868	45	42	87
	Norfolk	14,319	3,309	1,849	58	0	58
	Portsmouth	5,553	1,654	1,086	13	0	13
	Virginia Beach	23,509	2,156	1,527	56	118	174
	Western Tidewater	6,274	1,781	1,024	45	4	49
	TOTAL	394,748	86,232	42,912	4,327	703	5,030

Numbers of Children and Adolescents on CSB Mental Health Services Waiting Lists on April 11, 2003

	CSB	Est. Prevalence SED	Unduplicated Numbers from FY 2002 4th Quarter Report		On CSB Waiting Lists		Total on CSB Waiting List
			# Served	# SED	Receiving CSB Services	Not Receiving Some CSB Services	
I	Harrisonburg-Rockingham	1,058	387	338	13	4	17
	Northwestern	2,069	841	493	39	12	51
	Rappahannock Area	3,228	790	529	34	12	46
	Rappahannock-Rapidan	1,558	710	466	53	6	59
	Region Ten	2,061	576	420	4	1	5
	Rockbridge	365	243	189	20	0	20
	Valley	1,171	399	231	0	0	0
II	Alexandria	982	189	213	1	5	6
	Arlington	1,445	108	51	12	25	37
	Fairfax-Falls Church	11,719	1,417	427	42	24	66
	Loudoun	2,312	633	272	10	5	15
	Prince William	4,653	680	245	0	12	12
III	Alleghany-Highlands	248	184	111	3	1	4
	Blue Ridge	2,505	352	350	5	0	5
	Central Virginia	2,470	950	940	33	0	33
	Cumberland Mountain	987	313	263	218	84	302
	Danville-Pittsylvania	1,177	344	131	8	18	27
	Dickenson County	166	101	79	0	0	0
	Highlands	654	627	357	8	0	8
	Mount Rogers	1,194	571	484	98	17	115
	New River Valley	1,401	573	457	35	0	35
	Piedmont Regional	1,411	870	579	40	16	56
	P.D. 1	936	735	698	5	1	6
IV	Chesterfield	3,383	543	299	62	13	75
	Crossroads	1,013	558	403	9	10	19
	District 19	1,857	354	88	7	7	14
	Goochland-Powhatan	425	82	60	9	0	9
	Hanover	1,096	438	271	80	0	80
	Henrico	3,197	832	580	44	7	51
	Richmond BHA	1,955	1,154	650	25	0	25
	Southside	892	365	266	0	0	0
V	Chesapeake	2,619	297	200	77	39	116
	Colonial	1,466	318	175	19	0	19
	Eastern Shore	576	328	205	0	0	0
	Hampton-Newport News	3,894	1,378	1,346	0	0	0
	Middle Pen.-Northern Neck	1,386	452	287	28	26	54
	Norfolk	2,583	284	121	0	0	0
	Portsmouth	1,176	210	172	1	0	1
	Virginia Beach	5,367	795	694	29	0	29
	Western Tidewater	1,442	451	255	0	0	0
	TOTAL	80,097	21,432	14,395	994	320	1,314

Numbers of Adults on CSB Mental Retardation Services Waiting Lists on April 11, 2003

	CSB	Est. MR Prevalence	Unduplicated # Served FY 2002 4th Quarter Report	On CSB Waiting Lists Receiving CSB Services	On CSB Waiting Lists Not Receiving Some CSB Services	Total on CSB Waiting List
I	Harrisonburg-Rockingham	1,007	376	24	5	29
	Northwestern	1,715	698	71	11	82
	Rappahannock Area	2,193	829	118	5	123
	Rappahannock-Rapidan	1,247	377	69	15	84
	Region Ten	1,855	430	58	1	59
	Rockbridge	367	259	19	1	20
	Valley	1,039	420	46	4	50
II	Alexandria	1,190	520	7	0	7
	Arlington	1,773	244	73	4	77
	Fairfax-Falls Church	9,177	3,071	216	31	247
	Loudoun	1,499	626	55	65	120
	Prince William	2,926	1108	103	5	108
III	Alleghany-Highlands	219	184	8	2	10
	Blue Ridge	2,240	676	58	0	58
	Central Virginia	2,123	1,007	81	0	81
	Cumberland Mountain	955	463	52	1	53
	Danville-Pittsylvania	1,025	654	18	4	22
	Dickenson County	154	51	0	0	0
	Highlands	642	318	16	1	17
	Mount Rogers	1,136	577	119	21	140
	New River Valley	1,553	350	51	2	53
	Piedmont Regional	1,306	379	32	10	42
	P.D. 1	848	383	51	2	53
IV	Chesterfield	2,386	1079	320	16	336
	Crossroads	907	253	15	6	21
	District 19	1,552	1,024	19	62	81
	Goochland-Powhatan	366	168	3	0	3
	Hanover	794	288	55	0	55
	Henrico	2,597	1,056	93	1	94
	Richmond Behavioral	1830	993	97	0	97
	Southside	822	233	0	0	0
V	Chesapeake	1819	672	86	0	86
	Colonial	1,191	301	24	4	28
	Eastern Shore	333	388	11	8	19
	Hampton-Newport News	2,982	1068	122	38	160
	Middle Pen.-Northern Neck	1,247	509	15	0	15
	Norfolk	2,147	872	26	5	31
	Portsmouth	920	363	91	0	91
	Virginia Beach	3,882	1,114	10	2	12
	Western Tidewater	1,098	522	24	6	30
	TOTAL	65,062	24,903	2,320	336	2,656

Numbers of Adults on CSB Substance Abuse Services Waiting Lists on April 11, 2003

	CSB	Est. Prevalence of Drug & Alcohol Dependence (Ages 18+)	Unduplicated # Served FY 2002 4th Quarter Report	On CSB Waiting List s Receiving CSB Services	Not Receiving Some CSB Services	Total on CSB Waiting List
I	Harrisonburg-Rockingham	3,070	592	8	0	8
	Northwestern	5,054	1,113	106	10	116
	Rappahannock Area	6,163	3,202	73	32	105
	Rappahannock-Rapidan	3,623	1,201	20	12	32
	Region Ten	5,574	1,429	8	5	13
	Rockbridge	1,123	369	11	0	11
	Valley	3,098	1,013	10	20	30
II	Alexandria	3,843	1,740	27	0	27
	Arlington	5,696	1,282	32	0	32
	Fairfax-Falls Church	26,947	5,150	593	20	613
	Loudoun	4,286	1,223	50	5	55
	Prince William	8,180	2,290	35	45	80
III	Alleghany-Highlands	659	161	0	0	0
	Blue Ridge	6,716	1,437	225	46	71
	Central Virginia	6,307	1,977	0	0	0
	Cumberland Mountain	2,885	1,207	363	190	553
	Danville-Pittsylvania	3,048	1,135	47	24	71
	Dickenson County	460	115	0	0	0
	Highlands	1,956	1,012	18	2	20
	Mount Rogers	3,449	733	69	10	79
	New River Valley	4,852	1,196	0	0	0
	Piedmont Regional	3,921	908	10	20	30
	P.D. 1	2,546	422	120	1	121
IV	Chesterfield	6,713	1,703	68	1	69
	Crossroads	2,702	399	14	2	16
	District 19	4,571	854	60	11	71
	Goochland-Powhatan	1,090	228	16	4	20
	Hanover	2,266	214	19	1	20
	Henrico	7,671	1,410	123	15	138
	Richmond Behavioral	5,566	3,380	100	2	102
	Southside	2,472	489	0	0	0
V	Chesapeake	5,108	1,380	14	84	98
	Colonial	3,459	799	11	0	11
	Eastern Shore	1,405	396	0	0	0
	Hampton-Newport News	8,696	4,288	0	0	0
	Middle Pen.-Northern Neck	3,708	1,799	21	10	31
	Norfolk	6,410	3,975	59	3	62
	Portsmouth	2,690	880	9	0	9
	Virginia Beach	11,101	975	63	200	263
	Western Tidewater	3,164	743	14	84	98
	TOTAL	192,248	54,819	2,204	793	2,997

Numbers of Adolescents on CSB Substance Abuse Services Waiting Lists on April 11, 2003

	CSB	Est. Prevalence of Drug & Alcohol Dependence (Ages 12-17)	Unduplicated # Served FY 2002 4th Quarter Report	On CSB Waiting Lists Receiving CSB Services	On CSB Waiting Lists Not Receiving Some CSB Services	Total on CSB Waiting List
I	Harrisonburg-Rockingham	277	31	0	0	0
	Northwestern	550	107	0	13	13
	Rappahannock Area	841	342	0	0	0
	Rappahannock-Rapidan	437	60	0	0	0
	Region Ten	542	128	0	2	2
	Rockbridge	103	23	2	2	4
	Valley	325	15	0	0	0
II	Alexandria	200	205	0	0	0
	Arlington	321	33	4	10	14
	Fairfax-Falls Church	2,974	1,031	102	4	106
	Loudoun	482	550	16	0	16
	Prince William	1,131	661	0	0	0
III	Alleghany-Highlands	65	20	0	0	0
	Blue Ridge	661	80	0	0	0
	Central Virginia	667	157	0	0	0
	Cumberland Mountain	289	199	21	14	35
	Danville-Pittsylvania	329	217	17	3	20
	Dickenson County	49	20	0	0	0
	Highlands	179	391	0	0	0
	Mount Rogers	319	76	0	0	0
	New River Valley	370	302	8	2	10
	Piedmont Regional	396	218	0	0	0
	P.D. 1	260	14	3	0	3
IV	Chesterfield	953	255	0	0	0
	Crossroads	287	12	0	0	0
	District 19	502	158	4	1	5
	Goochland-Powhatan	114	14	0	1	1
	Hanover	296	129	1	0	1
	Henrico	803	159	9	0	9
	Richmond Behavioral	472	243	19	1	20
	Southside	246	24	0	0	0
V	Chesapeake	715	275	4	1	5
	Colonial	424	120	0	19	19
	Eastern Shore	1,56	46	0	0	0
	Hampton-Newport News	982	724	0	0	0
	Middle Pen.-Northern Neck	403	84	1	3	4
	Norfolk	613	130	0	0	0
	Portsmouth	304	56	0	0	0
	Virginia Beach	1,402	29	0	0	0
	Western Tidewater	390	20	0	0	0
	TOTAL	20,829	7,362	211	76	287

Appendix F
MR Home and Community-Based Waiver Waiting List by CSB and Region
August 2003

	CSB	Active Slots	Urgent Waiting List	Non-Urgent Waiting List
I	Harrisonburg-Rockingham	105	43	5
	Northwestern	147	35	44
	Rappahannock Area	197	49	41
	Rappahannock-Rapidan	121	25	12
	Region Ten	151	28	33
	Rockbridge Area	47	11	5
	Valley	131	36	13
II	Alexandria	66	1	5
	Arlington	49	18	13
	Fairfax-Falls Church	422	175	179
	Loudoun County	61	36	19
	Prince William County	151	27	62
III	Alleghany Highlands	34	3	8
	Blue Ridge	209	24	69
	Central Virginia	254	36	25
	Cumberland Mountain	100	28	12
	Danville-Pittsylvania	137	12	38
	Dickenson	15	1	0
	Highlands	73	6	12
	Mount Rogers	165	22	14
	New River Valley	104	21	9
	Piedmont	120	32	17
	Planning District 1	108	22	17
IV	Chesterfield	309	79	51
	Crossroads	102	9	30
	District 19	114	14	13
	Goochland-Powhatan	28	4	4
	Hanover County	79	19	54
	Henrico Area	159	64	51
	Richmond BHA	231	37	72
	Southside	130	11	0
V	Chesapeake	77	13	13
	Colonial	57	5	19
	Eastern Shore	86	9	15
	Hampton-Newport News	238	76	72
	Middle Peninsula-Northern Neck	119	7	8
	Norfolk	166	44	118
	Portsmouth	125	29	15
	Virginia Beach	318	43	57
	Western Tidewater	81	22	15
	TOTAL	5,386	1,176	1,259
			Total on Waiting list	2,435

Appendix G
Proposed State Facility Capital Priority Listing 2004-2010

Item	Project Type	Funds	Notes
Proposed for 2004-2006 Biennium			
Construct New SVP Facility	New Construction	$42,606,000	
Relocate Hancock Geriatric Center, ESH	Improvement	$15,318,000	150 beds
Renovate Boilers, Steamlines, HVAC, Phase 4	Improvement	$9,626,000	Steamlines at SVTC, CVTC, PGH SWVMHI
Life Safety Code Compliance, Phase 3	Improvement	$9,343,000	CVTC Bldgs 8, 9; Generators SWVMHI, PGH
Abate Environmental Hazards	Improvement	$2,334,000	Replace transite pipe, SWVTC
Renovate Site Utilities and Access, Phase 1	Improvement	$3,436,000	WSH
Planning for Replacement of ESH - MH Beds	Planning	$300,000	
Planning for Replacement of WSH	Planning	$300,000	
Renovations/Additions- Bldgs 1 and 4, NVTC	Improvement	$11,876,000	
Replacement Cottage, SEVTC, Phase 1	New Construction	$5,118,000	
Planning for Addition to Bldg 15 of PGH	Planning	$768,000	
Planning for Cottage Renovation, SWVTC	Planning	$678,000	
Demolition of Abandoned Buildings, Phase 1	Demolition	$4,114,000	
Total 2004-2006 Capital Request		$105,817,000	
Proposed for 2006-2008 Biennium			
Life Safety Code Compliance, Phase 4	Improvement	$6,907,000	Bldg 12 CVTC; CH; PGH
Renovate Boilers, Steamlines, HVAC, Phase 5	Improvement	$9,277,000	Steam & condensate at WSH, SVTC, CVTC
Abate Environmental Hazards	Improvement	$2,495,000	Replace transite pipe, SEVTC
Food Service Modifications	Improvement	$8,385,000	SEVTC and SWVMHI
Renovate Site Utilities and Access, Phase 2	Improvement	$3,145,000	SVTC, CH
Replacement Cottage, SEVTC, Phase 2	New Construction	$5,547,000	
Cottage Renovation, SWVTC, Phase 1	Improvement	$7,958,000	
Replacement Facility, ESH - MH Beds	New Construction	$52,572,000	
Construction of Addition to Bldg 15, PGH	New Construction	$9,395,000	Program space addition
Planning for Renovation/Replacement, CVTC	Planning	$511,000	
Renovate Building 95, CSH	Improvement	$6,171,000	
Cottage Renovation, NVTC, Phase 1	Improvement	$5,125,000	Building 3
Planning for Medically Acute Building, SVTC	Planning	$1,189,000	
Demolition of Abandoned Buildings, Phase 2	Demolition	$2,497,000	
Total 2006-2008 Capital Request		$121,174,000	
Proposed for 2008-2010 Biennium			
Renovate Boilers, Steamlines, HVAC, Phase 2	Improvement	$12,206,000	SWVMHI, SE & SWVTC Boilers; ESH steam lines
Renovate Site Utilities and Access	Improvement	$2,940,000	CVTC, SEVTC, and CH
Abate Environmental Hazards	Improvement	$2,813,000	NVTC transite chiller pipe
Replacement Cottage, SEVTC, Phase 3	New Construction	$5,783,000	
Construct Replacement Facility, WSH	New Construction	$54,848,000	
Cottage Renovation, NVTC, Phase 2	Improvement	$5,627,000	Buildings 5 and 6
Renovate Buildings 15 and 16, CVTC	Improvement	$8,513,000	
Planning: Renovate Bldgs 17 and 18, CVTC	Planning	$682,000	
Construct Medically Acute Building, SVTC	New Construction	$12,471,000	50 Beds
Renovate Building 94, CSH	Improvement	$6,388,000	
Cottage Renovation, SWVTC, Phase 2	Improvement	$3,711,000	
Planning: Environment of Care Bldg, SVTC	Planning	$437,000	
Planning for Patient Activity Building, CSH	Planning	$310,000	
Planning for Renovations to NVMHI	Planning	$852,000	Admin space and Parking
Demolition of Abandoned Buildings, Phase 3	Demolition	$2,445,000	
Total 2008-2010 Capital Request		$120,026,000	

DMHMRSAS Budget Initiative for Facility Energy Costs

The Department has had a continual program to reduce facility energy costs. On-going projects, initiated within the last few years, include the following:

Boiler Replacements The Department is in the process of replacing the last of its large, boiler plants. Originally coal fired, this plant will be replaced with new, energy efficient dual fuel (gas/oil) boilers. The updated plant will have improved control systems.

Steam line Repair/Replacement The Department is in the process of repairing and replacing old and leaking steam lines, traps, valves, and condensate return lines. This project will reduce steam demand and the amount of make-up water required.

Trap Maintenance Plan Associated with the steam line repairs, condensate return, and the abatement of asbestos within the tunnels, the Department is implementing a trap testing and maintenance plan. This will further reduce the steam demand at a facility with a central boiler plant.

Installation of Packaged Boilers Where appropriate, hot water and steam distribution systems are being replaced by the installation of small, packaged boiler units at individual buildings. This results in a reduction in heat costs.

Window Air Conditioning The Department is slowly improving the structures that are now being cooled with window air conditioners by installing central air systems. Window air conditioners are heavy energy users.

Reinsulation of Piping In the past, insulation for chilled and hot water was allowed to fall off or remain in a damaged condition because the insulation contained high concentrations of asbestos fibers. With asbestos abatement funds, the Department removed this material and properly reinsulated the piping, thereby saving energy.

Replacement of Central Kitchen Refrigeration Equipment Walk-in refrigerator and freezer boxes at the facilities are planned to be replaced in those food service buildings that were not previously replaced. Many of the electric motors and compressors were 30 to 40 years old and were high-energy users and high maintenance. This program will replace these old units with new, more energy efficient, units having improved insulation and energy saving motors and compressors.

Lighting Replacement The Department has installed full spectrum lighting at one facility, Southern Virginia Mental Health Institute, as a pilot project. It is anticipated that these bulbs will reduce energy requirements

Installations of DDC Controls New HVAC systems have been installed at SEVTC and SWVTC with DDC controls, allowing for improved energy efficiency.

Appendix H
Glossary of Department and Services System Terms and Acronyms

Acronym/Term	Name
AA	Alcoholics Anonymous
AAMR	American Association on Mental Retardation
ABS	Adaptive Behavior Scale (MR)
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act (U.S.)
ADA	Assistant Director Administrative (DMHMRSAS state facility position)
ADC	Average Daily Census
ADRDA	Alzheimer's Disease and Related Disorders Association
ADSCAP	AIDS Control and Prevention Project
AHCPR	Agency for Health Care Policy and Research
AITR	Agency Information Technology Resource
ALF	Assisted Living Facility (formerly Adult Care Residence)
ALOS	Average Length of Stay
AMA	Against Medical Advice
AOD	Alcohol and Other Drugs
AODA	Alcohol and Other Drug Abuse
APA	Administrative Process Act (Virginia)
APA	American Psychiatric Association
APA	American Psychological Association
Arc of Virginia	Association for Retarded Citizens of Virginia
ARR	Annual Resident Review
ASAM	American Society of Addiction Medicine
ASFA	Adoption and Safe Families Act of 1997 (U.S.)
ASI	Addiction Severity Index
AT	Assistive Technology
ATOD	Alcohol, Tobacco and Other Drugs
ATTC	Addiction Technology Transfer Center
AVATAR	State Facility Information Patient/Billing System (DMHMRSAS hospital billing system that replaced PRAIS)
AWOP	Absent Without Permission
BHA	Behavioral Health Authority
C&A	Child and Adolescent
CAFAS	Child and Adolescent Functional Assessment Scale
CAMI	Chemically Addicted/Mentally Ill (dual diagnosis)
CARF	Commission on Accreditation of Rehabilitation Facilities
CARS	Community Automated Reporting System (DMHMRSAS)
CASA	National Center on Addiction and Substance Abuse at Columbia University
CASSP	Child and Adolescent Service Systems Program
CBR	Center for Behavioral Rehabilitation (DMHMRSAS facility located in Dinwiddie)

CCCA	Commonwealth Center for Children and Adolescents (DMHMRSAS facility located in Staunton)
CCS	Community Consumer Submission (DMHMRSAS)
CELT	Consumer Education and Leadership Training
CH	Catawba Hospital (DMHMRSAS facility located near Salem)
CHAP	Child Health Assistance Program
CHRIS	Comprehensive Human Rights Information System (DMHMRSAS)
CLAS	Culturally and Linguistically Appropriate Services (standards)
CM	Case Management
CMHS	Center for Mental Health Services (U.S.)
CMS	Centers for Medicare and Medicaid Services (U.S.)
CO	Central Office (DMHMRSAS)
Coalition	Coalition for Mentally Disabled Citizens of Virginia
COBRA	Comprehensive Omnibus Budget Reconciliation Act (also OBRA)
CODIE	Central Office Data and Information Exchange (DMHMRSAS Intranet)
COPN	Certificate of Public Need
COY	Commission on Youth (Virginia)
CPI	Consumer Price Index
CPMT	Community Policy and Management Team
CRA	Commitment Review Committee
CRF	Classification Rating Form (MH-Adult)
CRIPA	Civil Rights of Institutionalized Persons Act (U.S.)
CSA	Comprehensive Services Act for Troubled Children and Youth (Virginia)
CSAO	Consortium of Substance Abuse Organizations (Virginia)
CSAP	Center for Substance Abuse Prevention (U.S.)
CSAT	Center for Substance Abuse Treatment (U.S.)
CSB	Community Services Board
CSH	Central State Hospital (DMHMRSAS facility located in Dinwiddie)
CSP	Community Support Program
CSQMC	Clinical Services Quality Management Committee (DMHMRSAS)
CSS	Community Support System
CVTC	Central Virginia Training Center (DMHMRSAS facility located near Lynchburg)
DAD Project	Discharge Assistance and Diversion Project (Northern Virginia)
DAP	Discharge Assistance Project
DARC	Division of Administration and Regulatory Compliance (DMHMRSAS Central Office)
DCS	Division of Community Services (DMHMRSAS Central Office)
DCHVP	Domiciliary Care for the Homeless Veterans Program
DCJS	Department of Criminal Justice Services (Virginia)
DD	Developmentally Disabled or Developmental Disabilities
DDHH	Department for the Deaf and Hard of Hearing (Virginia)
DJJ	Department of Juvenile Justice (Virginia)
DFA	Division of Financial Administration (DMHMRSAS Central Office)
DFM	Division of Facility Management (DMHMRSAS Central Office)
DHCD	Department of Housing and Community Development (Virginia)

DHHS	Department of Health and Human Services (U.S.) (or HHS)
DHQC	Division of Health and Quality Care (DMHMRSAS Central Office)
DI	Departmental Instruction
DMAS	Department of Medical Assistance Services (Virginia)
DMHMRSAS	Department of Mental Health, Mental Retardation and Substance Abuse Services (Virginia)
DOC	Department of Corrections (Virginia)
DOE	Department of Education (Virginia)
DOJ	Department of Justice (U.S.)
DPB	Department of Planning and Budget (Virginia)
DPSP	Division of Programs for Special Populations (U.S.)
DRGs	Diagnosis-Related Groups
DRS	Department of Rehabilitative Services (Virginia)
DSM-IV	Diagnostic and Statistical Manual (Mental Disorders), Fourth Edition
DVH	Department for the Visually Handicapped (Virginia)
EBP	Evidence-Based Practice
ECA	Epidemiologic Catchment Area
ECO	Emergency Custody Order
EI	Early Intervention
EIA	Early Intervention Assistance
EMTALA	Emergency Medical Treatment and Active Labor Act
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ER	Emergency Room
ESH	Eastern State Hospital (DMHMRSAS facility located in Williamsburg)
FAPT	Family Assessment and Planning Team
FAS	Fetal Alcohol Syndrome
FFP	Federal Financial Participation (Medicaid)
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FHA	Federal Housing Administration (U.S.)
FMLA	Family and Medical Leave Act
FMR	Fair Market Rent (U.S. Housing and Urban Development)
FMS - II	Financial Management System (DMHMRSAS)
FRP	Forensic Review Panel (DMHMRSAS)
FTE	Full Time Equivalent
GA	General Assembly (Virginia)
GAF	Global Assessment of Functioning
GOSAP	Governor's Office for Substance Abuse Prevention (Virginia)
HCB	Home and Community-Based (Medicaid MR Waiver)
HGTC	Hancock Geriatric Treatment Center (at Eastern State Hospital in Williamsburg)
HHR	Health and Human Resources Secretariat (Virginia)
HIE	Homeless Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HJR	House Joint Resolution

HMO	Health Maintenance Organization
HPR	Health Planning Region
HPSA	Health Professional Shortage Area
HRDM	Human Resources Development and Management Office (in DMHMRSAS Central Office)
HRIS	Human Resources Information System (DMHMRSAS)
HRSA	Health Resources and Services Administration (U.S.)
HSA	Health Services Area
HUD	Housing and Urban Development (U.S.)
HVAC	Heating, Ventilation, and Air Conditioning
HWDMC	Hiram W. Davis Medical Center (DMHMRSAS facility located in Dinwiddie)
I&R	Information and Referral
IAPSRS	International Association of Psychosocial Rehabilitation Services
ICD	International Classification of Diseases
ICES	Integrated Client Events System (DMHMRSAS)
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICT	Intensive Community Treatment
IDEA	Individuals with Disabilities Education Act (U.S.)
ILPPP	University of Virginia Institute of Law, Psychiatry and Public Policy
IMD	Institution for the Mentally Disabled (CMS term)
INS	Immigration and Naturalization Service (U.S.)
ISP	Individualized Services Plan
IP	Inpatient
IPA	Independent Practice Association
IQ	Intelligence Quotient
IS	Information Systems
ISN	Integrated Service Network
IT	Information Technology
JAIBC	Juvenile Accountability Incentive Block Grant (federal block grant)
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCHC	Joint Commission on Health Care
JJDPA	Juvenile Justice Delinquency Prevention Act (U.S.)
LAAM	Levo-Alpha Acetyl Methadol (an opiate blocking agent used like methadone)
LAR	Legally Authorized Representative
LEAP	Leadership-Empowerment-Advocacy Program
LEP	Limited English Proficient
LGD	Local Government Department (a type of CSB)
LHRC	Local Human Rights Committee
LOF	Level of Functioning
LOS	Length of Stay
LSC	Life Safety Code
LTC	Long Term Care
MCH	Maternal and Child Health
MCO	Managed Care Organization

MDR	Multidrug-Resistant
Medicaid DSA	Medicaid Disproportionate Share Adjustments
Medicaid DSH	Medicaid Disproportionate Share Hospital
MESA	Mutual Education, Support, and Advocacy
MH	Mental Health
MHA-V	Mental Health Association of Virginia
MHI	Mental Health Institute
MHPC	Mental Health Planning Council
MHPRC	Mental Health Policy Resource Center
MHSIP	Mental Health Statistics Improvement Program
MHWG	Mental Health Work Group (of the Northern Virginia Regional Partnership)
MIC	Maternal and Infant Care
MICA	Mentally Ill/Chemical Abuser (dual diagnosis)
Mid-ATTC	Mid Atlantic Addiction Technology Transfer Center
MI/MR	Mentally Ill/Mentally Retarded (dual diagnosis)
MI/SA	Mentally Ill/Substance Abuser (dual diagnosis)
MMWR	Morbidity and Mortality Weekly Report
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MR	Mental Retardation
MR/MI	Mentally Retarded/Mentally Ill (dual diagnosis)
MR Waiver	Medicaid Mental Retardation Home and Community-Based Waiver
MUA	Medically Underserved Area
NA	Narcotics Anonymous
NADD	National Association for the Dually Diagnosed
NAEH	National Alliance to End Homelessness
NAFARE	National Association for Family Addiction, Research and Education
NAMI	National Alliance for the Mentally Ill
NAMI -VA	National Alliance for the Mentally Ill - Virginia
NAPH	National Association of Public Hospitals
NAPWA	National Association of People with AIDS
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NASDDDS	National Association of Directors of Developmental Disabilities Services
NASMHPD	National Association of State Mental Health Program Directors
NASTAD	National Alliance of State and Territorial AIDS Directors
NCADD	National Council on Alcoholism and Drug Dependence
NCADI	National Clearinghouse for Alcohol and Drug Information
NCCAN	National Center on Child Abuse and Neglect
NCH	National Coalition for the Homeless
NCS	National Comorbidity Survey
NCSACW	National Center for Substance Abuse and Child Welfare
NF	Nursing Facility
NGF	Non-general Funds

NGRI	Not Guilty by Reason of Insanity
NHCHC	National Health Care for the Homeless Council
NHIS-D	National Health Interview Survey Disability Supplement
NHSDA	National Household Survey on Drug Abuse
NIAAA	National Institute on Alcohol and Alcohol Abuse (U.S.)
NIDA	National Institute on Drug Abuse (U.S.)
NIH	National Institute of Health (U.S.)
NIMH	National Institute on Mental Health (U.S.)
NVMHI	Northern Virginia Mental Health Institute (DMHMRSAS facility located in Falls Church)
NVTC	Northern Virginia Training Center (DMHMRSAS facility located in Fairfax)
OAE	Office of Architectural and Engineering Services (DMHMRSAS Central Office)
OAG	Office of the Attorney General (Virginia)
OAS	Office of Administrative Services (DMHMRSAS Central Office)
OB	Budget Office (DMHMRSAS Central Office)
OBRA	Omnibus Budget Reconciliation Act of 1989 (U.S.)
OBS	Organic Brain Syndrome
OCAR	Office of Cost Accounting and Reimbursement (DMHMRSAS Central Office)
OCC	Office of Community Contracting (DMHMRSAS Central Office)
OFRC	Office of Financial Reporting and Compliance (DMHMRSAS Central Office)
OFS	Office of Forensic Services (DMHMRSAS Central Office)
OFS	Office of Fiscal Services (DMHMRSAS Central Office)
OGM	Office of Grant Management (DMHMRSAS Central Office)
OHR	Office of Human Rights (DMHMRSAS Central Office)
OIA	Office of Internal Audit (DMHMRSAS Central Office)
OIG	Office of the Inspector General (Virginia)
OIM	Office of Investigations Management (DMHMRSAS Central Office)
OITS	Office of Information Technology Services (DMHMRSAS Central Office)
OL	Office of Licensing (DMHMRSAS Central Office)
OLIS	Office of Licensing Information System (DMHMRSAS)
OLPR	Office of Legislation and Public Relations (DMHMRSAS Central Office)
OMHRC	Office of Minority Health Resource Center (U.S.)
OMHS	Office of Mental Health Services (DMHMRSAS)
OMRS	Office of Mental Retardation Services (DMHMRSAS Central Office)
ONAP	Office of National AIDS Policy (U.S.)
OPD	Office of Planning and Development (DMHMRSAS Central Office)
OQI	Office of Quality Improvement (DMHMRSAS Central Office)
OQM	Office of Quality Management (DMHMRSAS Central Office)
OP	Outpatient
ORLA	Office of Risk and Liability Affairs (DMHMRSAS Central Office)
OSAS	Office of Substance Abuse Services (DMHMRSAS Central Office)
OSHY	Outreach Services for Homeless Youth
OT	Occupational Therapy
OUR	Office of Utilization Management (DMHMRSAS Central Office)

PACCT	Parents and Children Coping Together
PACT	Program of Assertive Community Treatment
PAIMI	Protection and Advocacy for Individuals with Mental Illnesses Act (U.S.)
PAIR	Parents and Associates for the Institutionalized Retarded
Part C	Part C of the IDEA (Federal funds for early intervention services)
PASARR	Pre-Admission Screening/Annual Resident Review
PATH	Projects for Assistance in Transition from Homelessness (federal grant)
PBPS	Performance-Based Prevention System
PEATC	Parent Educational Advocacy Training Center
PGH	Piedmont Geriatric Hospital (DMHMRSAS facility located in Burkeville)
PHA	Public Health Association
PHS	Public Health Service (U.S.)
PHWG	Private Hospital Work Group (of the Northern Virginia Regional Partnership)
PIP	Program Improvement Plan
PKI	Public Key Infrastructure
PL	Public Law (U.S.)
PMPM	Per Member Per Month
POIS	Purchase of Individualized Services
Pony Walls	Half-Height Walls in State Facility Patient Living Areas
POS	Purchase of Services
PPAC	Prevention and Promotion Advisory Council
PPC	Patient Placement Criteria
PPEIA	Public Private Educational and Infrastructure Act of 2002 (Virginia)
PPO	Preferred Provider Organization
PPW	Pregnant and Postpartum Women
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (U.S)
PRAIS	Patient Resident Automated Information System (DMHMRSAS)
PRC	Perinatal Resource Center
PSR	Psychosocial Rehabilitation
PT	Physical Therapy
PTSD	Post Traumatic Stress Disorder
PWA	Persons with AIDS
QA	Quality Assurance
QI	Quality Improvement
QMHP	Qualified Mental Health Professional
QMRP	Quality Mental Retardation Professional
Region I	Northwest Virginia
Region II	Northern Virginia
Region III	Southwestern Virginia
Region IV	Central Virginia
Region V	Eastern Virginia
RM	Risk Management
RPAC	Restructuring Policy Advisory Committee (Virginia)

SA	Substance Abuse
SAARA	Substance Abuse and Addiction Recovery Alliance
S+C	Shelter Plus Care
SACAVA	Substance Abuse Certification Alliance of Virginia
SAMHSA	Substance Abuse and Mental Health Services Administration (U.S.)
SANAP	Substance Abuse Needs Assessment Project
SAPT	Substance Abuse Prevention and Treatment (Block Grant)
SARPOS	Substance Abuse Residential Purchase of Services
SEC	State Executive Council (of Comprehensive Services Act)
SED	Serious Emotional Disturbance
SEVTC	Southeastern Virginia Training Center (DMHMRSAS facility located in Chesapeake)
SGF	State General Funds
SHRC	State Human Rights Committee
SJR	Senate Joint Resolution
SMHA	State Mental Health Authority
SMI	Serious Mental Illness
SMSA	Standard Metropolitan Statistical Area
SNF	Skilled Nursing Facility
SPMI	Serious and Persistent Mental Illness
SPO	State Plan Option (Medicaid)
SRO	Single Room Occupancy
SRO	School Resource Officer
SSA	Social Security Administration (U.S.)
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
State Board	State Mental Health, Mental Retardation and Substance Abuse Services Board
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder
SVMHI	Southern Virginia Mental Health Institute (DMHMRSAS facility located in Danville)
SVP	Sexually Violent Predator
SVTC	Southside Virginia Training Center (DMHMRSAS facility located in Dinwiddie)
SWG	Structural Work Group (of the Northern Virginia Regional Partnership)
SWVBHB	Southwest Virginia Behavioral Health Board
SWVMHI	Southwestern Virginia Mental Health Institute (DMHMRSAS facility located in Marion)
SWVTC	Southwestern Virginia Training Center (DMHMRSAS facility located in Hillsville)
TANF	Temporary Assistance for Needy Families (federal block grant)
TB	Tuberculosis
TBI	Traumatic Brain Injury
TC	Training Center (state mental retardation facility)
TDO	Temporary Detention Order
TEDS	Treatment Episode Data Set
TFSASO	Task Force on Substance Abuse Services for Offenders (Virginia)
TIP	Treatment Improvement Protocols (CSAT)

TRW	Transition to Reinvestment Workgroup (of the SWVBHB)
TWWIIA	Ticket to Work and Work Incentives Improvement Act of 1999
UAI	Uniform Assessment Instrument
UM	Utilization Management
UR	Utilization Review
URICA	University of Rhode Island Change Assessment
VAADAC	Virginia Association of Alcoholism and Drug Abuse Counselors
VACSB	Virginia Association of Community Services Boards
VACO	Virginia Association of Counties
VADAP	Virginia Association of Drug and Alcohol Programs
VAHA	Virginia Adult Home Association
VAHMO	Virginia Association of Health Maintenance Organizations
VALHSO	Virginia Association of Local Human Services Officials
VANHA	Virginia Association of Nonprofit Homes for the Aging
VASAP	Virginia Alcohol Safety Action Program (Commission on)
VASH	Veterans Administration Supported Housing
VATTC	Virginia Addictions Technology Transfer Center
VDEM	Virginia Department of Emergency Management
VDMDA	Virginia Depressive and Manic-Depressive Association
VEC	Virginia Employment Commission (Virginia)
VHHA	Virginia Hospital and Healthcare Association
VHCA	Virginia Health Care Association
VHDA	Virginia Housing Development Agency (Virginia)
VHST	Virginia Human Services Training Center
VICC	Virginia Interagency Coordinating Council
VIACH	Virginia Interagency Action Council on Homelessness
VICH	Virginia Interagency Council on Homelessness
VIPACT	Virginia Institute for Professional Addictions Counselor Training
VITA	Virginia Information Technologies Agency
VITC	Virginia Intercommunity Transition Council
VML	Virginia Municipal League
VOCAL	Virginia Association of Consumers Asserting Leadership
VOPA	Virginia Office for Protection and Advocacy
VPCA	Virginia Primary Care Association
VPN	Virtual Private Network
VR	Vocational Rehabilitation
VRHRC	Virginia Rural Health Resource Center
WIB	Workforce Investment Board
WRAP	Wellness Recovery Action Plan
WSH	Western State Hospital (DMHMRSAS facility located in Staunton)

Appendix I
Comprehensive State Plan 2004-2010 Reference Documents

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